Health Care Financing Administration Rulings

On Medicare, Medicaid, Professional Standards Review and Related Matters

Publication No. MBR-1 (11-78)

PREFACE

The *Health Care Financing Administration Rulings* is published under the authority of the Administrator, Health Care Financing Administration for the purpose of making available to the public official rulings relating to the Medicare, Medicaid, Professional Standards Review Organizations and other programs under his jurisdiction.

The Rulings include materials required to be made public by the Freedom of Information Act (5 U.S.C. 552(a)(1)): that is, final opinions, including concurring and dissenting opionions, as well as orders made in the adjudication of cases; statements of policy and interpretations adopted by the Health Care Financing Administration or one of its components and not published in the *Federal Register;* and indexes of administrative staff manuals and instructions to staff that affect a member of the public.

The first edition of the *Health Care Financing Administration Rulings* contains most of the previously published *Social Security Rulings* concerning Medicare program matters that were issued under the authority of the Commissioner of Social Security, as well as new rulings of the Administrator for other programs under his jurisdiction. Subsequent editions will carry, in addition to new items, the remainder of previously published *Social Security Rulings* concerning Medicare.

With the exception of HCFA R78–43c at page 117 and HCFA R78–44a at page 129, which are being issued for the first time, the rulings formerly issued by the Social Security Administration regarding Medicare program issues are being reprinted in their entirety without change, including reference to the Code of Federal Regulations Part 20 where Medicare program regulations were found prior to October 1, 1977. Medicare regulations have now been recodified in Part 42 of the Code of Federal Regulations. The CFR reference will be changed in the cumulative bulletin issued at the end of the year.

Case decisions decided in the Federal courts upon appeal from the decision of the Secretary, HEW, are identified by a suffix "c" after the ruling number. Cases decided by the Appeals Council of the Bureau of Hearings and Appeals, Social Security Administration, representing the final decision of the Secretary, are identified by a suffix "a" after the ruling number.

The rulings will be published quarterly, with an annual cumulative compilation of all quarterly issues for the calendar year. Copies of the rulings may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402 at a cost of $1.75 per copy for each quarterly publication ($2.20 for foreign mailings) and $2.50 for each cumulative edition ($3.50 foreign). The full subscription price is $7.00 per year ($8.50 for foreign subscriptions).

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HCFAR–78–1

Where an individual, not having been hospitalized previously during his entitlement to benefits under Part A of title XVIII of the Act, spends 3 or more consecutive days in a hospital that meets all but the utilization review and health and safety requirements of section 1861(e) of the Act, and subsequently a home health plan meeting all the requirements of section 1861(n) of the Act is established within 14 days after his discharge from the hospital, *held*, payment cannot be made under Part A of title XVIII for home health services received under such plan, because hospitalization in such a hospital did not commence a spell of illness. Payment can be made under Part A for home health services only if the Part A beneficiary first commences a spell of illness by receiving inpatient hospital services in a hospital meeting *all* the requirements of section 1861(e) of the Act, or in a hospital which furnished him covered inpatient emergency services, or by receiving post-hospital extended care services in an extended care facility. A spell of illness is the statutory unit of measurement which establishes the period during which each series of post-hospital home health visits may commence and recommence for purposes of Part A payments.

Payment may be made under Part A of title XVIII of the Social Security Act for post-hospital home health services furnished an insured individual in his home for up to 100 visits within 1 year after discharge from a hospital in which he was an inpatient for at least 3 consecutive days or (if later) within 1 year after discharge from an extended care facility in which he was an inpatient entitled to payment under Part A for post-hospital extended care services. The individual must be in the care of a physician and a plan for furnishing home health services must be established within 14 days after his discharge from the hospital or extended care facility.

Advice has been requested as to whether payment may be made under Part A of title XVIII for home health services furnished an insured individual under the following circumstances. The insured individual, who was not hospitalized previously during his entitlement to benefits under Part A, is hospitalized for 3 or more consecutive days in an institution which does not meet the requirements of the Act to qualify as a hospital in the health insurance program, and within 14 days after his discharge from the institution a home health plan meeting the requirements of the Act is established. The question is whether such hospitalization is sufficient to meet the requirements of the Act for payment for home health services under Part A.

In order to qualify as a hospital in the health insurance program established by title XVIII of the Act, an institution must be a "hospital" within the meaning of section 1861(e) of the Act. Section 1861(e) sets out eight specific requirements which must be met by qualified hospitals, two of which require that the institution:

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k) [section 1861(k) of the Act];

* * * * * * *

and (8) meets such other requirements as the Secretary finds necessary in the interest of health and safety of individuals who are furnished services in the institution * * *.

However, section 1861(e) also provides that for purposes of section 1861(n) of the Act (in which the term "post-hospital home health services" is defined), the term "hospital" includes institutions that do not meet the above-quoted requirements in section 1861(e)(6) and (8) but do meet the other six requirements of section 1861(e).

Section 1861(n) provides in pertinent part that the term "post-hospital home health services" means:

> * * * home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from an extended care facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services * * * is established within 14 days after his discharge from such hospital or extended care facility.

Hence, a plan for furnishing home health services, which meets all the requirements of section 1861(n), could be established for an individual after his discharge from a hospital which is not a qualified hospital because it does not meet all the requirements of section 1861(e) of the Act.

However, section 1812(a)(3) of the Act describes the home health benefits payable under Part A of title XVIII as:

> (3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) *after the beginning of one spell of illness* and before the beginning of the next * * *. (Emphasis supplied.)

Section 1861(a)(1) of the Act provides that a spell of illness can begin only "* * * with the first day (not included in a previous spell of illness) (A) on which such individual is furnished *inpatient hospital services* or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A * * *." (Emphasis supplied.) The term "inpatient hospital services," as defined in section 1861(b) of the Act, refers to services received in a hospital which meets *all* the requirements of section 1861(e) of the Act or to emergency services received in an institution which meets the special requirements for emergency services in section 1814(d) of the Act.

Thus, where an insured individual, not having been hospitalized previously during his entitlement to Part A benefits, spends 3 or more consecutive days in a hospital which meets all but the utilization review and health and safety requirements of section 1861(e), and subsequently a home health plan meeting all the requirements of section 1861(n) is established within 14 days after discharge from the hospital, the question to be resolved is whether payment under Part A for home health services provided under such plan would be precluded by section 1812(a)(3) because the stay in the hospital did not start a spell of illness.

In setting forth the benefits an individual is entitled to under Part A of title XVIII, section 1812(a)(3) of the Act makes clear that post-

hospital home health services are not to be furnished unless they follow the beginning of a spell of illness. A spell of illness is one of the time control devices established to define the amount of insurance coverage the individual receives under his entitlement to Part A institutional benefits. Its existence not only establishes a time period within which such benefits may accrue but also provides a limitation on how much service may be compensated for under the program. Similarly, because there is a limitation on the number of post-hospital home health visits which may be received under the program following any spell of illness, it is necessary to relate the post-hospital home health services to the incidents which measure the spell of illness in order to assure to the beneficiary full program protection. Thus, home health services, which are measured in terms of numbers of incidents of services beginning with a spell of illness, rather than in terms of time interludes, must be counted by reference to the spell of illness to which they are related. For example, if an individual were to have received 89 home health visits within the 1-year period following discharge from a hospital and thereafter the beneficiary required additional hospitalization or other covered institutional care, a new spell of illness would commence, providing him with additional post-hospital home health service protection of up to 100 visits, and not 11 visits remaining from the prior spell of illness.

If entitlement to post-hospital home health services were established simply by hospitalization in an unqualified hospital, not only would the quality standards of the health insurance program be removed, but also the unit of measurement of coverage would not be retained. While the number of home health visits could be counted from discharge from the hospital, however defined, it would be impossible to re-establish a base from which a new series of home health visits could be counted after exhaustion of the first 100-visit series.

The provisions of sections 1812(a)(3) and 1861(n), on the other hand, take cognizance of the fact that home health services may be required after the close of a spell of illness, e.g., after 60 days have elapsed from the time of discharge from a hospital or extended care facility. In such a case, a second condition precedent is introduced to measure utilization and not to establish eligibility, namely, the requirement in section 1861(n) that there be at least 3 days of hospitalization not more than 14 days prior to the institution of the plan of home health services. The 1-year period following such hospitalization measures the time interlude within which the 100-visits can be covered under Part A. Unless a new spell of illness commences, there would be no further eligibility for home health services after the 1-year period.

For example, should an insured individual be admitted to a qualified hospital for 1 day of inpatient hospital services, a spell of illness for the individual would begin with such inpatient hospital services. Should he require no further institutional care for the next 3 years, but then is admitted to a hospital which meets all requirements for participation other than the utilization review and health and safety requirements of section 1861(e), and after 3 days of hospital services is discharged from that hospital, and within 14 days a plan for home health services is

developed by his physician, payment may be made under Part A for 100 home health visits to the individual during the 1-year period after discharge from the hospital. Unless a new spell of illness should commence thereafter, payment could not be made for additional home health services, even if the individual should again be admitted for a 3-day period to the same nonqualified hospital which qualified him for the first series of home health visits, because under the provisions of section 1861(a) inpatient hospital services in a nonqualified hospital would not begin a new spell of illness.

To summarize, for a spell of illness to begin under the provisions of section 1861(a), an individual must be furnished with inpatient hospital services (or extended care services) within a month in which he is entitled to Part A benefits. Inpatient hospital services, defined in section 1861(b), means "items and services furnished to an inpatient of a hospital * * *." The exceptions from some of the requirements of section 1861(e) are not applicable to "hospitals" as that term is used in section 1861(a)(1) and (b).

Accordingly, it is *held* that to start a spell of illness, an individual must become a patient in a hospital meeting all the requirements of section 1861(e) (that is, in a qualified hospital), or must receive emergency services in a hospital which meets the special requirements for emergency services in section 1814(d), or must become a patient in an extended care facility. Consequently, for payment to be made under Part A for post-hospital home health services, the individual must have been a patient at some point in such a hospital (or extended care facility) so that his spell of illness could come into existence.

(X—refer to SSR–67–30)

SECTION 1861(e).—HOSPITAL INSURANCE BENEFITS—CERTIFICATION OF HOSPITAL AS PROVIDER OF SERVICES—CONDITIONS OF PARTICIPATION

20 CFR 405.1010 ff. HCFAR–78–2

Where a community hospital which was not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, filed a request to establish eligibility to participate as a provider of services under the title XVIII health insurance program, and a survey of its facilities and personnel revealed it was not a "hospital" as defined in section 1861(e) of the Social Security Act because of failure to meet all the statutory requirements and was not in substantial compliance with all of the Conditions of Participation found necessary for the health and safety of individuals furnished services there as prescribed in Social Security Administration Regulations No. 5 (20 CFR 405.1010 ff.), *held* the community hospital is not entitled to certification as a provider of services under the Act and regulations promulgated thereunder.

X Community Hospital filed a Request to Establish Eligibility as a provider of services under section 1861(e) of the Social Security Act, as amended, and, as the result of a survey of its facilities and personnel, was advised that it did not meet the requirements for participation in the "Medicare" program

of the Act and was not therefore entitled to certification as such.

As pertinent here, the term "provider of services" means a "hospital" which is defined in section 1861(e) of the Act as "an institution which

> (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
>
> (2) maintains clinical records on all patients;
>
> (3) has bylaws in effect with respect to its staff of physicians;
>
> (4) has a requirement that every patient must be under the care of a physician;
>
> (5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
>
> (6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);
>
> (7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and
>
> (8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of section 1863). * * *

The statutory requirements for participation by a hospital provider in section 1861(e), supra, include eight specific conditions, the last of which authorizes the Secretary to establish by regulation such further conditions as may be necessary in the interest of health and safety. The Secretary has no authority or discretion to waive or permit less than complete compliance with any of these requirements; they are legislatively imposed, with no permissible latitude of application. They must be fully met by the applying institution. In addition, there must be *substantial* compliance with such other conditions as may be imposed by the Secretary for reasons of health and safety. The Secretary, by duly promulgated regulations, has amplified on the statutory conditions and has prescribed certain other necessary requirements for participating hospital providers. These are referred to as conditions of participation, and are set out in Subpart J, Regulations No. 5 of the Social Security Administration (20 CFR 405.1010, et seq.).

Under certain circumstances, a provider of hospital services may be "deemed" to meet most of these conditions for participation. Thus, if an institution is either currently accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association, such hospital, with an appropriate utilization review plan, may be deemed to meet the conditions of participation. In the absence of such accreditation, which is the situation here, the applicant must show either that it meets the specific statutory requirements of section 1861(e) and is operating in accordance

with all other conditions of participation with no significant deficiencies; or it meets these statutory requirements but is found to have deficiencies with respect to one or more of the other conditions of participation, which it is making reasonable plans and efforts to correct and, notwithstanding the deficiencies, is rendering adequate care and without hazard to the health and safety of individuals being served, taking into account special procedures or precautionary measures which have been or are being instituted. Section 405.1005, Social Security Administration Regulations No. 5 (20 CFR 405.1005).

In determining whether an institution is in substantial compliance with the conditions of participation, criteria established by the Secretary with respect to evaluation of the evidence presented are pertinent. Thus, consideration is given to the degree to which each standard, as well as the total set of standards, relating to a condition of participation is met; where there is a deficiency in meeting a standard, consideration is given to whether it is one concerning the statutory requirements which all hospitals must meet; whether the deficiency creates a serious health and safety hazard; and whether the hospital is making reasonable plans and efforts to correct the deficiency within a reasonable period. (20 CFR 405.1009) Cognizance is taken of variances from institution to institution, dependent on its type and size and on the nature and scope of services offered by each, reflected in differences in the details of organization, staffing, and facilities, but the overall test of substantial compliance with each of the conditions must be met.

Evaluation of the facts in this case in the light of these criteria shows that the applicant hospital is not in substantial compliance with the following specific conditions of participation, for the reasons outlined below:

(*a*) *Section 405.1021, Regulations No. 5* (*20 CFR 405.1021*) requires that the institution applying for certification have an effective governing body legally responsible for its conduct, either formally organized or otherwise. Standing as a vanguard for users of the facility, its necessity as a strong and functioning component of the institutional structure cannot be minimized, even in the smaller institutions.

The principal impediment to an effective governing body in the instant case relates to the fact that it is not operating under adopted written bylaws. Aside from X Community Hospital's failure to operate under written bylaws, there is no documentation to show that the ostensible governing board is carrying out the ordinary functions to be expected of an effectively operating governing board. Rather, the evidence presented indicates a complete lack of direction by the board over the hospital's chief executive officer, the Administrator. The evidence presented appears, therefore, to fall short of supporting a conclusion that the applicant hospital has an effective governing body operating in accordance with written bylaws, as required by this condition.

(*b*) *Section 405.1023, Regulations No. 5* (*20 CFR 405.1023*) relating to the medical staff requires that the hospital have a medical staff organized

under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members. The objective of this condition cannot be accomplished unless there is a staff arrangement designed in some form to insure that the highest professional competency is directed toward the single purpose of providing the highest quality medical care and treatment possible.

This institution has only three physicians, operating as a close-knit organization on a day-to-day basis, with the staff operating as a committee of the Whole for its purposes. However, no minutes of staff meetings were ever made until June 1966, and conclusions reached at current staff meetings are not written down. Assuming that the staff does act as a committee of the Whole, there is a lack of evidence to show that appropriate liaison is maintained by this committee with the Board of Trustees; that the committee has acted affirmatively to rectify the deficiencies noted in the medical records (see (*d*) below); that the committee members jointly review and evaluate pathological reports; or that the Committee has reviewed, analyzed or evaluated the clinical work of its members. It does not therefore appear that the medical staff of the applicant is operating in such a manner as to be in substantial compliance with the pertinent Condition of Participation.

(*c*) *Section 405.1024, Regulations No. 5* (*20 CFR 405.1024*) requires that the institution have an organized nursing department; that a licensed registered professional nurse be on duty *at all times* and professional nursing service be available for all patients *at all times*. This condition is buttressed by statute, which specifically includes, as part of the definition of a hospital, that 24-hour nursing service be rendered or supervised by a registered professional nurse. There must be a registered professional nurse in charge of the operating rooms. Under established working relationships in the hospital, there must be conferences relative to patient care between the registered professional nurses and the physicians. There is required a constant review and evaluation of the nursing care provided for patients. There is also a requirement that regular monthly meetings, with minutes recorded, be held by the registered professional nursing staff to discuss patient care, nursing service problems and administrative policies.

The evidence in this case shows that a registered nurse is not on duty at all times. There are two 8-hour shifts, biweekly, in which no registered nurse is on duty; a registered nurse is "on call" for the two uncovered shifts. This arrangement appears to be tenuous in that the Administrator has no way of knowing where the "on call" nurse might be at a given time. A nurse, who is not paid for being on call, may not be considered reasonably available in case of an immediate need for her services by a patient. Hospital emergencies do not accommodate a particular shift or time of day. They can and do occur at any time and the requirement for expert nursing personnel to be on hand at all times is in recognition of this fact.

There are other deficiencies. The evidence does not establish that a regis-

tered professional nurse is in charge of the operating room. Moreover, there is a total absence of conferences, except on an individual day-to-day basis, between the nursing and medical staff relating to patient care. Additionally, the record fails to reveal the existence of any effective review and evaluation of nursing care provided for patients as called for. The same is equally true with respect to the requirement for regular monthly meetings by the registered professional nursing staff to discuss patient care, nursing service problems and administrative policies. In summary, the nursing department of the applicant is not operated at a level commensurate with the overall requirements of the Conditions of Participation and, more *specifically*, it does not meet the statutory requirement for 24-hour registered nursing care or supervision for patients.

(*d*) *Section 405.1026, Regulations No. 5* (*20 CFR 405.1026*) requires that an applicant hospital have a medical record department which maintains, in accordance with accepted professional principles, a medical record for every patient admitted for care in the hospital. Among other things, the standards for this condition are concerned with the indexing, filing, content, promptness of preparation and signing of the medical records. These records should contain sufficient information to justify the diagnosis and warrant the treatment and end results. Only members of the medical staff and the house staff are competent to write or dictate medical histories and reports of physical examinations. The records should be authenticated and signed by a licensed physician. Current records and those on discharged patients should be completed promptly; within 24–48 hours following admission, and within 15 days following discharge of patients.

It appears from the record that the deficiencies alleged with respect to this department are largely confined to these areas, and involve the duties of the medical staff in relation to the records, i.e., the content, promptness of preparation and signing. Apparently the majority of records were not properly completed, nor signed. In the inspection of the charts of 8 or 10 patients, there was in some instances an absence of clinical information such as past history and admitting diagnoses. The records of discharged patients were not completed within 15 days following discharge.

Promptly and properly prepared clinical records are of utmost importance in the treatment and care of patients. Codification and filing of such records has its measure of importance under this Condition; however, no matter how well coded or how well indexed such records may be, they do not serve their intended purpose if they are lacking in the essential clinical information relating to the patient such as history, diagnosis, treatment, and prognosis. The same is equally true if there is inordinate delay in including such information in the record. Although the Administrator of the community hospital stated there had been recent improvements in the filing and disease codification of records, she did not specifically mention that there had been any change or improvement in the content of such records or that the records were being timely and properly completed and signed. Considering the relative importance of the various standards under this Condition, and while

conceding that there has been improvement in some aspects, the record as constituted still fails to sustain a conclusion that the medical records of the applicant hospital are maintained in such a professional manner as to be in substantial compliance with this Condition.

(*e*) *Section 405.1027, Regulations No. 5* (*20 CFR 405.1027*) requires that the applicant hospital have a pharmacy directed by a registered pharmacist or, in the alternative, a drug room under competent supervision, either of which is to be administered in accordance with accepted professional principles.

A small institution such as the applicant cannot afford and is not required to have a full-time pharmacist. There appears to be no reason why it could not afford the services of the local druggist as a consulting pharmacist for the purpose of drawing up procedures, rules and regulations for the drug room. It is not enough merely to set aside space for a drug room and put a lock on the premises. Numerous factors are involved in the issue and use of drugs and such factors require professionally drawn and established procedures of such particularity that risks of misuse are reduced to the barest minimum.

From the evidence, it appears that the Administrator of the hospital is left to her own resources, without professional medical or pharmaceutical advice, to devise the procedures for control and issue of drugs. The procedures governing operation of the drug room and the administration of drugs appear to lack the formality and preciseness necessary to ensure against hazards to the safety and health of the patients, as contemplated by the law and pertinent regulations.

Based on all the facts, the applicant institution does not meet the statutory definition of "hospital" in section 1861(e) of the Act, quoted above, nor is it in substantial compliance with all of the conditions of participation set out in Subpart J, Regulations No. 5 of the Social Security Administration. It is accordingly *held*, that the X Community Hospital is not now entitled to certification as a provider of hospital services under the provisions of title XVIII of the Act and Regulations No. 5 of the Social Security Administration.

(X—refer to SSR–69–11)

SECTION 1866.—PROVIDER-AGREEMENT WITH NURSING HOME—EFFECT OF ASSUMPTION OF TITLE BY TRUSTEE IN BANKRUPTCY

HCFAR–78–3

Where a provider is adjudged bankrupt, continuation of the provider's enterprise by a trustee in bankruptcy pursuant to court order, *held* not in itself such a change in ownership as to require the execution of a new section 1866 agreement, since there is neither the purchase of an ownership interest by the trustee nor a correlative transfer of the intrusted property to a new, non-obligated party.

After approval as an "extended care facility" within the meaning of section 1861(j) of the Social Security Act, and entering into a Provider Agreement for participation in the Medicare program, a nursing home has been adjudged bankrupt and is being operated by a trustee in bankruptcy acting for the creditors under Chapter 10 of the Bankruptcy Act (Title 11 U.S.C. 501 et seq.). The facility continues to admit medicare patients on the assumption that it will be paid under the provisions of title XVIII of the Social Security Act governing agreements with providers of services. The trustee's administration is authorized by an "Order Approving Petition and Appointing Trustee," issued by the bankruptcy court. This order explicitly provides that the bankrupt provider be operated without interruption and on a continuing basis. In pertinent part it provides as follows:

9. That said Trustee is hereby vested with power to administer the said property * * *; to continue to operate, manage and control the business of the debtor as heretofore conducted by the debtor for an indefinite period * * *; to perform existing contracts of the debtor and to enter into and perform other contracts in the regular course of the conduct of the business * * *.

An institution or organization which qualifies as a provider of services under section 1861 of the Act may participate and become eligible for payments under the title XVIII health insurance program if it files an agreement with the Secretary pursuant to section 1866 of the Act. Such agreement, which may be terminated by either party as provided under section 1866(b), also ceases to be effective when the contracting party can no longer be required to abide by its terms (e.g., because of a change in ownership). In view of the trustee's assumption of title to the bankrupt nursing home in the instant case, a question is raised as to whether this terminates the 1866 agreement entered into with the provider, so as to require a new survey and certification, title VI clearance, and the conclusion of a new provider agreement.

Where the original contracting provider ceases to exist as a legal entity or as the operating provider, neither the statute nor the section 1866 agreement provides for continuing coverage for Medicare beneficiaries. The reason for this gap in coverage is that the section 1866 Provider Agreement is with a

"person" in the legal sense (that is, an individual, a partnership, a corporation or other recognizable entity) and that being personal to the contracting party, it cannot be enforced against another party. The effect of a transfer of ownership of a provider facility is that patients of the facility are not covered under title XVIII unless the facility reapplies, meets the applicable conditions for participation, and concludes a Provider Agreement in accordance with section 1866 of the Act.

However, such is not the situation when there is a mere transfer of legal title to a trustee in bankruptcy. In that situation there is neither the purchase of an ownership interest by the trustee nor a correlative transfer of the intrusted property to a "new," non-obligated party. The effect of bankruptcy and the appointment of a trustee of the bankrupt's estate has been described as follows:

> The estate of the bankrupt is devolved upon the trustee, subject to the rights of other persons therein. The substance in which those rights inhere is impounded. But * * * it is the same substance, with the same incidents as before. The court takes it into its exclusive dominion and control, and, in harmony with the general principle of law governing the exercise of jurisdiction in such cases, it accords to every person who has an interest in the res the privilege of intervening and establishing his rights in the thing which has been seized. * * * The trustee is the hand of the court. He stands as its agent to liquidate the assets, to protect them, and bring them before the court for final distribution. He is not, in fact, more representative of one creditor or claimant than another. The trustee, in the procedure, because he has the legal title to the assets, and is charged with the duty of saving and protecting them, represents the general fund. He is not a purchaser, but as the title of his office imports, he is trustee for all who have interests, and according to those interests. He himself has no interest and there is nothing in his representation which stands between the court and those who have interests, for the recognition and protection of which they appeal to its authority. *In Re Ducker*, 134 F. 43 at 46–47 (1905).

There is in the present instance an explicit authorization to continue the operation of the business on the same basis as before. While explicit action (i.e., notice to the Secretary) by the trustee in bankruptcy is needed to terminate the Provider Agreement, he need not formally acknowledge his willingness to continue to be bound by the section 1866 agreement.

Thus, it may be noted that the trustee—having assumed the mutual obligations of the bankrupt—would be deemed to stand in the place of the bankrupt not only with regard to his rights but also as to his obligations under the Provider Agreement. It is accordingly *held* that the section 1866 Provider-Agreement with the nursing home is not terminated by reason of the assumption of title thereto by a trustee in bankruptcy who continues to administer and operate the facility pursuant to a court order issued under chapter 10 of the Bankruptcy Act (Title 11, U.S.C. 501 et seq.).

(X—refer to SSR–69–12)

SECTION 1814.—PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED—EMERGENCY SERVICES REQUIREMENT FOR NONPARTICIPATING PROVIDER

20 CFR 405.152 HCFAR–78–4

Where an individual entitled to hospital insurance benefits under title XVIII of the Social Security Act was furnished inpatient hospital services by a hospital not qualified as a participating provider under title XVIII, *held,* hospital not entitled to have payment made to it when it was not established that the hospital services constituted "emergency services" within the meaning of section 1814 of the Act and regulations thereunder.

On March 6, 1967, A, who was entitled to hospital insurance benefits under title XVIII of the Social Security Act, was admitted to X Hospital because of an acute upper respiratory infection. A signed a request that the hospital be paid on his behalf for the services furnished him. On March 7, 1967, A's attending physician signed a mimeographed form containing the statement that "the patient required emergency services to prevent death or serious impairment of the health of this individual and which, because of the threat to the life or health of the individual, necessitated the use of this the most accessible hospital available equipped to furnish such services." On March 13, 1967, A was discharged from the X Hospital, having received drug therapy which improved his condition. On that date, the X Hospital, which is not a participating provider under title XVIII, submitted a statement requesting payment from the Social Security Administration for emergency inpatient hospital services furnished to A.

Section 1814 of the Act provides, in pertinent part, that payment for hospital services furnished an individual may be made only to providers of services who, by agreement with the Secretary, have qualified to participate in title XVIII of the Social Security Act. However, payment will also be made to any hospital for inpatient hospital services furnished by it to an individual entitled to hospital insurance benefits, even though such hospital is not a participating provider under title XVIII if, in addition to other requirements which are not at issue herein, such services were emergency services.

The issue to be resolved is whether the inpatient hospital services furnished A by the X Hospital constitute "emergency services" within the meaning of section 1814 of the Act, and regulations of the Administration promulgated thereunder.

Emergency services are those inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services.

A determination as to whether services furnished are "emergency services"

will, ordinarily, be based upon the apparent condition of the patient at the time of his arrival at the hospital or upon a physician's conclusions as to his condition following examination of the patient. No payment under the hospital insurance program can be made to a nonparticipating hospital for services furnished after the emergency has ended. Also, hospital services are no longer considered "emergency services" when it is no longer necessary, from a medical standpoint, to care for the patient in a nonparticipating hospital.

The facts show that A had been suffering from a respiratory impairment over an extended period of time. He was examined by his attending physician on March 5, 1967, because of respiratory difficulties, and was advised to enter the hospital. However, A told the doctor he would wait until the next day to see if his condition improved and, if it did not, he would take the doctor's advice. When his condition did not improve, A entered X Hospital the next day, March 6, 1967. Hospital records show that he was admitted for the relief of chest pains, sore throat, coughing and hoarseness. A routine chest x-ray examination made on March 7 was interpreted as revealing the existence of fibrosis and emphysema and an otherwise negative chest. Treatment by means of drug therapy resulted in improvement and he was discharged a week later.

A has not contended—nor does the evidence of record establish—that his admission to the X Hospital was in the nature of an emergency, as defined above, that a hospital participating under title XVIII was not available, or that the X Hospital was the most accessible hospital available equipped to furnish the hospital services which he required. He waited one day before acting on the doctor's advice to enter a hospital. In addition, the record reveals that there were two hospitals participating under title XVIII, which were available to A, but he preferred to be hospitalized at the X Hospital, since his attending physician treated his patients there, and A's wife and stepson were also patients there. A's selection of the X Hospital was his free choice, made voluntarily for personal reasons entirely unassociated with any existing emergency. A's right to obtain hospitalization at any hospital he chooses is unquestioned. However, in order for payment to be made on his behalf by reason of the fact that he has been furnished hospital services, it must be established that the services were furnished either by a hospital participating under title XVIII, or, if by a nonparticipating hospital, that the services were "emergency services" as defined above. It is well-established by numerous court decisions that one who files a claim with an administrative agency has the burden of proving that the required conditions of eligibility have been met. See Norment v. Hobby, 124 F. Supp. 489. The claimant here has not met that burden.

It is accordingly *held* that the inpatient hospital services furnished A by the X Hospital do not constitute "emergency services" within the meaning of section 1814 of the Social Security Act and regulations thereunder, and payment may not be made on A's behalf to the X Hospital, a nonparticipating provider under title XVIII of the Act.

(X—refer to SSR–69–22)

SECTIONS 1842 and 1869.—SUPPLEMENTARY MEDICAL INSURANCE —APPEAL FROM CARRIER'S DETERMINATION DENYING REIMBURSEMENT—JUDICIAL REVIEW

HCFAR–78–5c

KUENSTLER *v.* OCCIDENTAL LIFE INS. CO., 292 Fed. Supp. 532 (C.D. of Calif., 1968)

A claim for reimbursement of medical expenses incurred by a Part B (supplementary medical insurance) beneficiary, was denied by an insurance carrier engaged to administer the benefit provisions of Part B under the terms of section 1842 of the Social Security Act. The claimant sought judicial review of the denial in the Small Claims Court, and later in the United States District Court, after removal of the action thereto was ruled proper. His claim was dismissed by the United States District Court for lack of jurisdiction and failure of the plaintiff to state a claim upon which relief could be granted, on the basis of the following conclusions of law: (1) the United States of America is the real party in interest in this action, since the insurance carrier was acting at all times as its duly authorized agent; (2) the plaintiff had no statutory right to judicial review of his claim against the United States of America under the provisions of title XVIII of the Social Security Act; (3) thus, the United States of America had not waived its sovereign immunity against suit with respect to this claim and had not consented to suit against its agent; (4) therefore, the court lacked jurisdiction over the parties to the action.

HAUK, *District Judge:*

The above-mentioned matter came on for hearing on Sptember 23, 1968, before the Court, Honorable A. Andrew Hauk, United States District Judge, presiding, on defendant's Motion to Dismiss, no appearance being made by plaintiff acting in propria persona, and defendant appearing by its attorneys, Wm. Matthew Byrne, Jr., United States Attorney; Frederick M. Brosio, Jr., Assistant U. S. Attorney, Chief of Civil Division; and David H. Anderson, Assistant U. S. Attorney; by David H. Anderson, and this Court having considered the pleading on file herein, having heard oral argument from counsel, and having announced its decision, makes its Findings of Fact, Conclusions of Law, and Decision as follows:

FINDINGS OF FACT

1. Plaintiff filed an action in the Small Claims Court, Los Angeles Judicial District, County of Los Angeles, State of California, seeking recovery of $72.00 in medical expenses from the defendant.

2. Defendant is a private insurance company which has contracted with the Federal Government to administer the benefit provisions of Part B of Title XVIII of the Social Security Act, known as Health Insurance for the Aged (Medicare), Public Law 89–97.

3. Plaintiff's claim arises out of medical expenses incurred by him which were submitted to defendant for reimbursement under the provisions of Part B of Title XVIII and disallowed by defendant as nonreimbursable.

4. Prior to the time set for appearance in the Small Claims action, the defendant filed a Petition for Removal in the United States District Court, Central District of California, and a copy of this Petition along with a Notice of Filing of Petition for Removal were filed in the Small Claims Court.

5. The presiding judge of the Small Claims Court ruled that this action had been transferred to the United States District Court and that the Small Claims Court no longer had jurisdiction to act upon plaintiff's claim.

6. After removal of plaintiff's action to this Court, defendant filed a Motion to Dismiss for lack of jurisdiction and failure to state a claim upon which relief can be granted.

7. The following Conclusions of Law, insofar as they may be considered Findings of Fact, and also found by the Court to be true in all respects. From the foregoing facts the Court concludes that:

CONCLUSIONS OF LAW

I

The defendant is the duly authorized agent of the United States of America in administering the benefit provisions of Part B of Title XVIII of the Social Security Act, Public Law 89–97.

II

The United States of America is the real party in interest in this action.

III

This action was properly removed from the Small Claims Court to the United States District Court pursuant to 28. U.S.C. § 1442(a)(1).

IV

This Court has jurisdiction to determine whether it has jurisdiction to decide upon the merits of plaintiff's claim.

V

Plaintiff has no statutory right to judicial review of his claim under the provisions of Title XVIII of the Social Security Act.

VI

The United States of America has not waived its sovereign immunity with respect to this claim.

VII

This Court lacks jurisdiction over the parties as this is an unconsented to suit against an agent of the United States of America.

VIII

Plaintiff has failed to state a claim upon which relief can be granted.

DECISION

THE DEFENDANT IS THE DULY AUTHORIZED AGENT OF THE UNITED STATES OF AMERICA IN ADMINISTERING THE BENEFIT PROVISIONS OF PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT.

Title XVIII of the Social Security Act, entitled Health Insurance for the Aged, was passed by Congress in 1965 as Public Law 89–97 and later codified as 42 U.S.C. § 1395 etc. and referred to by its popular name "Medicare." Part A of this Act is entitled "Hosptial Insurance Benefits for the Aged" while Part B is entitled "Supplementary Medical Insurance Benefits for the Aged." Part B provides for the establishment and administration of the voluntary insurance program which supplements the regular Medicare benefits. The administration of benefits under this part is handled by private "carriers" who contract to provide this service pursuant to U.S.C. § 1395u:

> (a) In order to provide for the administration of the benefits under this part (Part B) with maximum efficiency and convenience for individuals entitled to benefits under this part . . ., the Secretary (of Health, Education, and Welfare) is authorized to enter into contracts with carriers . . . which will perform some or all of the following functions . . .: (1) (A) make determination of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable); (B) receive, disburse, and account for funds in making such payments . . . .

For purposes of this Act, the term "carrier" is defined in 42 U.S.C. § 1395u(f) (1) as follows:

> . . . with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization. . . .

In accordance with 42 U.S.C. § 1395u, the Secretary of Health, Education, and Welfare entered into a contract with the defendant for the latter to administer the benefit provisons of Part B. The defendant, while acting in this capacity, is the duly authorized agent of the United States of America through the Secretary of Health, Education, and Welfare).

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE IS THE REAL PARTY IN INTEREST IN THIS ACTION.

The regulations established pursuant to title XVIII were published on August 8, 1968, in 33 Federal Register at pp. 11274–11281 and provide for the administration of the benefit provisions of Part B of this Act by private carriers. 20 C.F.R. § 405.670 includes the following provision:

> . . . In the performance of their contractual undertakings, the carriers act on behalf of the Secretary, carrying on for him the administrative responsibil-

ities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program and will endeavor to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts entered into by them with the Secretary.

In addition to this regulation, the contract between the defendant and the Secretary of Health, Education, and Welfare provides, at paragraph XIV, for indemnification of the carriers (defendant) as follows:

> In the event the Carrier or any of its directors, officers, or employees are made parties to any judicial or administrative proceeding arising, in whole or in part, out of any function of the Carrier under this agreement in connection with any claim for benefits by any individual or his assignee, then the Secretary shall hold the Carrier harmless for all judgments, settlements, and costs, in favor of such individual or his assignee, incurred by the Carrier or any of its directors, officers or employees in connection therewith. The Carrier shall reimburse the United States for the amount of any valid judgment or award paid by the United States in the discharge of the Secretary's obligations under this Article if the court rendering the judgment or the agency making the award finds or otherwise determines that the liability underlying the judgment or award was the direct consequence of criminal conduct or gross negligence or fraud on the part of the Carrier.

The defendant, while administering the benefit provisions of Part B, is acting on behalf of the real party in interest, which is the United States of America acting through the Secretary of Health, Education, and Welfare.

THIS ACTION WAS PROPERLY REMOVED FROM THE SMALL CLAIMS COURT PURSUANT TO 28 U.S.C. § 1442(a)(1).

Authority to remove this action from the Small Claims Court to the United States District Court is based upon 28 U.S.C. § 1442(a)(1):

> (a) A civil action or criminal prosecution commenced in a State court against any of the following persons may be removed by them to the district court of the United States for the district and division embracing the place wherein it is pending:
> (1) Any officer of the United States or any agency thereof, or person acting under him, for any act under color of such office . . .

This is an action against a person (defendant) acting under an officer of the United States of America (Secretary of Health, Education, and Welfare), and such person was acting under color of office in administering the benefit provisions of Part B of Title XVIII. The action was therefore properly removed from the Small Claims Court to this Court.

THIS COURT HAS JURISDICTION TO DETERMINE WHETHER IT HAS JURISDICTION TO DECIDE UPON THE MERITS OF PLAINTIFF'S CLAIM.

If this Court has jurisdiction over the subject matter of this action, then this would be the proper forum in which to decide the issues upon their merits since the defendant was acting under authority of an officer of the United States of America as its duly authorized agent. *State of Texas* v. *National Bank of Commerce of San Antonio*, 290 F.2d 229 (5th Cir., 1961), *cert. denied* 368 U.S. 832.

While this Court is limited in its jurisdiction over the parties or subject matter of an action, it does have jurisdiction to decide whether or not it has jurisdiction over the parties or the subject matter, and whether it can decide upon the merits of the claim. *Moore's Federal Practice,* § 60.25(2); *Chicot County Drainage District* v. *Baxter State Bank,* 308 U.S. 371, 376 (1940); *Yanow* v. *Weyerhaeuser Steamship Co.,* 274 F.2d 274 (9th Cir., 1959), aff. 356 U.S. 937. *In Stoll* v. *Gottlieb* 305 U.S. 165 (1938), the Court stated,

> A court does not have the power, by judicial fiat, to extend its jurisdiction over matters beyond the scope of the authority granted to it by its creators. There must be admitted, however, a power to interpret the language of the jurisdictional instrument and its application to an issue before the court. Where adversary parties appear, a court must have the power to determine whether or not it has jurisdiction of the person of a litigant, or whether its geographical jurisdiction covers the place of the occurrence under consideration. Every court in rendering a judgment, tacitly, if not expressly, determines its jurisdiction over the parties and the subject matter. . . .

Therefore this Court does have jurisdiction over this action to enable it to determine whether it has jurisdiction to decide upon the merits of plaintiff's claim.

PLAINTIFF HAS NO STATUTARY RIGHT TO JUDICIAL REVIEW OF HIS CLAIM UNDER THE PROVISIONS OF TITLE XVIII OF THE SOCIAL SECURITY ACT.

The plaintiff is seeking to recover the amount of $72.00 allegedly paid by him for medical services which were disallowed by defendant. Plaintiff submitted this claim to defendant for reimbursement and defendant made a determination that plaintiff's claim did not qualify for reimbursement. Any rights to judicial review of determinations made by the defendant are governed by the provisions of Title XVIII of the Social Security Act as codified in 42 U.S.C. § 1395 ff:

> (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) Any individual dissatisfied with any determination under subsection (a) of this section as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

There is no right to judicial review of questions relating to the amount of benefits to which plaintiff is entitled to receive reimbursement. This section clearly limits the right to judicial review to claims of $1,000 or more. However, in addition to this requirement as to amount, judicial review is possible only where the Secretary of Health, Education, and Welfare has reached a

final decision, and claims as to the amount of benefits under Part B are excluded from review by the Secretary no matter what the amount. Therefore, there is no judicial review of the amount of claims under Part B of Title XVIII.

The reasoning behind this exclusion of judicial review is discussed in the report of the Committee on Finance, Senate Report No. 404, at pp. 54–55:

> The committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary medical insurance benefits and for hearings by the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the amount in controversy is $1,000 or more. (*Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.*) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program. It is intended that the remedies provided by these review procedures shall be exclusive. (Emphasis supplied.)

42 U.S.C. § 1395u(b)(3)(C) requires the Secretary of Health, Education, and Welfare to provide in its contracts with the carriers for procedures to be utilized by the carriers to provide fair hearings on all disputed claims. This relieves the courts of the burden of reviewing and deciding upon the merits of the many small claims involved in the administration of Part B, such as plaintiff's claim for $72.00.

Therefore plaintiff has no statutory right to judicial review of his claim and this Court lacks jurisdiction over the subject matter of this action.

THIS COURT LACKS JURISDICTION OVER THE PARTIES AS THIS IS AN UNCONSENTED TO SUIT AGAINST AN AGENT OF THE UNITED STATES OF AMERICA.

Judicial review of benefit claims arising under Part B of Title XVIII is specifically excluded by 42 U.S.C. § 1395 ff. In order for the plaintiff to sue the defendant, an agent for the United States of America, there must be a waiver of sovereign immunity. The plaintiff must allege a specific Federal statute granting jurisdiction to this Court. However, jurisdiction over plaintiff's claim is specifically excluded by Federal statute, so that this action becomes an unconsented to suit against the United States of America as the real party in interest. Therefore, this court lacks jurisdiction over the parties to this action.

Reid v. *United States*, 211 U.S. 529 (1909).
Blackmar v. *Guerre*, 342 U.S. 512 (1952).
Dalehite v. *United States*, 346 U.S. 15 (1953).

In addition, 42 U.S.C. § 1395ii specifically incorporates the provisions of 42 U.S.C. § 405(h), which provides in part:

> No findings of fact or decision of the Secretary (of Health, Education, and Welfare) shall be reviewed by any person, tribunal or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

By implication this section would preclude any action against the defendant also, as the policy for excluding such action is the same in either case. The courts have held that sovereign immunity from suit is removed except to the extent and in the manner provided by this section. *Satterfield* v. *Celebrezze*, 244 F. Supp. 190 (D.C.S.C., 1965).

PLAINTIFF HAS FAILED TO STATE A CLAIM UPON WHICH RELIEF CAN BE GRANTED.

For the reasons given hereinabove, the plaintiff has failed to state a claim upon which relief can be granted and this Court lacks jurisdiction over the subject matter and parties to this action.

ORDER

By reason of the foregoing Findings of Fact, Conclusions of Law, and Decision,

IT IS HEREBY ORDERED that judgment be entered against plaintiff, Philip Kuenstler, and in favor of defendant, Occidental Life Insurance Company, dismissing plaintiff's claim.

(X—refer to SSR–69–48c)

SECTION 1842.—SUPPLEMENTARY MEDICAL INSURANCE—NOTICE OF GARNISHMENT SERVED ON CARRIER—JUDICIAL REVIEW

ALLEN *v.* ALLEN, 291 Fed. Supp. 312 (S.D., Ia., 1968) HCFAR–78–6c

Plaintiff had been granted judgment in a suit for separate maintenance against her husband, a physician, in a State court. In an attempt to satisfy the judgment and reach monies allegedly owing her husband for services rendered under the Medicare program she caused a notice of garnishment to be served upon the Iowa Medical Service, a carrier engaged under the terms of section 1842 of the Social Security Act to administer the Part B benefit provisions of title XVIII of the Act. The case was ruled properly removed to the United States District Court pursuant to 18 U.S.C.A., Section 1442(a)(11). Garnishment proceedings were dismissed by the United States District Court on the basis of the following conclusions of law: (1) the United States of America and not the Iowa Medical Service is the real party in interest in this action, since the insurance carrier was acting at all times as its duly authorized agent for the purpose of paying claims under title XVIII of the Social Security Act; (2) plaintiff had not demonstrated that the United States of America had waived its sovereign immunity against suit with respect to this claim and consented to a garnishment suit against its agent; and (3) therefore the plaintiff's action could not be maintained.

HANSON, *District Judge:*

This ruling is predicated upon plaintiff Ardis Allen's motion to remand and motion by Iowa Medical Service, garnishee herein, to dismiss garnishment proceedings and quash garnishment.

The instant controversy originated when a separate maintenance action was commenced in the District Court of Iowa in and for Davis County, wherein Ardis Allen was the plaintiff and Richard L. Allen was the defendant. The State Court entered a decree requiring Richard L. Allen to pay to Ardis Allen certain monthly amounts. Richard L. Allen is a medical doctor who has treated qualifying patients pursuant to the Medicare Program of the Social Security Act. The Secretary of the Department of Health, Education, and Welfare has entered into a contract with Iowa Medical Service, garnishee herein, for the evaluation and processing by the latter of Medicare claims in Iowa, certain of which are alleged to be owing to Richard L. Allen.

Subsequent to rendition and entry of the above State Court judgment, plaintiff Ardis Allen caused to be served upon Iowa Medical Service a garnishment of Medicare funds in its control by reason of contract with the Secretary of the Department of Health, Education, and Welfare, is to be substantially identified with the latter agency for purposes of sovereign immunity.

A suit, however captioned, is one against the United States if the judgment sought would expend itself on the public treasury or interfere with the public administration. See Land *v.* Dollar, 330 U.S. 731 (1947). The *results* of the judgment or decree which may be entered should be of controlling importance. See New Mexico *v.* Backer, 199 F.2d 426 (10th Cir. 1952); Jones *v.* Tower Prod. Co., 138 F.2d 675 (10th Cir. 1943).

Here, the Department of Health, Education, and Welfare is obligated by contract to reimburse Iowa Medical Service for costs of administration including "the amounts of any judgment, settlement, costs, expenses, or other expenditures directly or indirectly incurred" in connection with "any judicial or administrative proceeding arising . . . out of any function of the Carrier under this agreement." It must be admitted that routine allowance of garnishment process in the circumstances of the instant case would, through inevitable disruption in Iowa Medical Service's task of evaluating and paying claims, substantially increase the costs of administration. Such costs, under the contract, would in turn be allocable to the Department of Health, Education, and Welfare. In terms of the result of any judgment, the decree sought would both expend itself on the public treasury and interfere with the public administration.

But there is another reason why the Court believes that Iowa Medical Service should be identified with the Department of Health, Education and Welfare for purposes of immunity. Iowa Medical Service is a private corporation. It may, however, by contract become the agent of the agency. Funds forwarded from the agency to Iowa Medical Service are in no sense the "property" of the latter entity. Rather, Iowa Medical Service is given custody

of these funds, all of which by contract must be retained in a separate account, for the limited purpose of disbursing such funds to recipients. Its sole ambit of discretion arises in determining the reasonableness of claims. When a claim has been deemed reasonable, it must be paid from the special fund or not at all. Iowa Medical Service thus stands, for purposes of *paying* claims, in the shoes of the governmental agency, enjoying no greater discretion than that of the agency. But for convenience of administration the claims might equally well be paid directly by the agency itself.

In view of this Court's determination that plaintiff Ardis Allen's suit is one against the United States, it became her duty to demonstrate affirmatively the consent of Congress to be sued in these circumstances. Plaintiff has not met this burden, nor has the Court's independent effort revealed the existence of any such consent. It follows that plaintiff's action cannot be maintained.

Accordingly, it will be ordered that plaintiff's motion to remand is overruled. Further, it will be ordered that the motion by Iowa Medical Service to dismiss garnishment proceedings and quash garnishment is sustained.

(X—refer to SSR–69–49c)

SECTION 206(a)—HEALTH INSURANCE—FRAUD AND MISREPRESENTATION—UNAUTHORIZED USE OF "MEDICARE" IN PRIVATE BUSINESS NAMES

HCFAR–78–7

Held, while use of the word "Medicare" as part of a private firm name is not prohibited by Federal statute, active misrepresentation or willful deception by use of the word "Medicare" to imply an official connection with the United States Government or to defraud social security beneficiaries, may constitute a violation of section 206 of the Social Security Act and of other Federal statutes, which is punishable under Federal law.

A number of medical equipment suppliers have been using the word "Medicare" as part of their firm names, as shown in their general advertising matter and in telephone listings. In one instance a firm has taken two listings in the Yellow Pages of the local telephone directory, one under its long-established firm name, and one under the name "Medicare Equipment Rental and Sales Company." Both show the same address and phone number. In another instance, a firm which has incorporated the word "Medicare" in its business name, answers "Medicare" when called by telephone. Since the health insurance program established under title XVIII of the Social Security Act is popularly known as "Medicare," there has been considerable concern lest these practices mislead the public generally, and beneficiaries under the program in particular, into believing that they are dealing with an official agency of the United States Government rather than wtih a private businesss entity. In view of this potential for public misunderstanding, and, in some instances, for deception and fraud on the public, the question has been raised whether use of the word "Medicare" by a private firm as part of its name is unlawful.

The word "Medicare" does not connote an official status or connection with the administration of title XVIII of the Act; rather, it is an unofficial designation for the Federal health insurance program. The Federal criminal statute, 18 U.S.C. 709, prohibits only the use of specifically enumerated official governmental names (i.e., Federal, United States, and the like) as part of a business or firm name. Therefore, use of the word "Medicare" in a firm's name or in a firm's telephone response does not in and of itself violate any Federal law.

The term, however, is identified in the public mind with the program. Its use, therefore, may violate the laws of those States which prohibit using as part of a business name any word denoting the United States Government or relating to an agency or to an activity of the United States Government. Further, adding the word "Medicare" as part of a firm's name in advertising or in the local telephone directory may contravene the laws of those States which forbid operating a business within the State unless the business is registered under its business name. There may thus be remedies available under State law to control the possible abuse of the word "Medicare" in private business names and in multiple telephone listings.

Notwithstanding the fact that there is no Federal statute prohibiting use of the word "Medicare" as part of any private firm's business name, there are remedies available to the Federal Government (as well as to the States) to control actual abuse of the word. Thus, where there is evidence of active misrepresentation or willful deception of beneficiaries, the Administration has an obligation to investigate, and initiate prosecution for violations of Federal law which are found to have occurred. Advertisements suggesting to beneficiaries that a firm or sales representative may have an official connection with the United States Government might constitute violations of section 206(a) of the Social Security Act, (42 U.S.C. 406) which provides, in pertinent part, that:

> (a)(C) * * * Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead or threaten any claimant or prospective claimant or beneficiary * * * by word, circular, letter, or advertisement, shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding 1 year, or both.

They might, in addition, violate one or more of the following Federal statutes: 15 U.S. Code 52 (The Federal Trade Commission Act), which prohibits false advertisements "in commerce by any means, for the purpose of inducing * * * , directly or indirectly, the purchase of food, drugs devices or cosmetics"; or 18 U.S.C. 912, which makes it unlawful to obtain money or anything of value by pretending to be an officer or employee acting under the authority of the United States Government or any of its departments or agencies.

(X—refer to SSR–69–58)

SECTIONS 1814(a) and 1862(a)(9).—HOSPITAL INSURANCE BENEFITS—INPATIENT PSYCHIATRIC HOSPITAL SERVICES—CUSTODIAL CARE EXCLUSION

20 CFR 405.310(g) HCFAR–78–8

An individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was admitted as an inpatient to a psychiatric hospital on October 18, 1968, and placed under observation for 6 weeks to assess whether her condition would improve with proper diet, regular vitamins, and tranquilizers. By November 28, 1968, it became apparent that her condition had deteriorated beyond the point where any treatment could reasonably be expected to improve her condition. *Held*, payment of hospital insurance benefits may not be made for services furnished by the hospital after November 28, 1968, because such services did not constitute inpatient psychiatric hospital service within the meaning of section 1814(a) of the Social Security Act.

K, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act, was admitted as an inpatient to a psychiatric hospital on October 18, 1968, and discharged January 2, 1969. Payment for inpatient psychiatric hospital care and services furnished by the hospital has been made on K's behalf for the period from October 18, 1968, through November 28, 1968. However, payment has been denied for the remainder of K's stay, i.e., from November 29, 1968, through January 2, 1969, on the basis that the care and services she required and received were not "inpatient psychiatric hospital services" within the meaning of section 1814(a) of the Social Security Act but were instead supportive in nature and therefore excluded from coverage by the custodial care exclusion contained in section 1862(a)(9) of the Act.[1] K's husband has protested this decision.

The insurance benefits provided an individual under Part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including inpatient psychiatric hospital services, for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness. This is subject to the limitation that payment under title XVIII for inpatient psychiatric hospital services is limited to 190 days during an individual's lifetime.

Section 1814(a) of the Act provides, as pertinent here, that payment for services furnished an individual may be made only to providers of service, and only if:

> (2) a physician certifies (and recertifies, . . . with such frequency, and accompanied by such supporting material, . . . as may be provided by regulations, . . .) that
>
> (A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

[1] For discussion of the term "custodial care" see SSR 69–51a, C.B. 1969, p. 169.

* * * * * * *

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

Section 1861 of the Social Security Act provides, as pertinent here, that:

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements, excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern; and

(5) the services of a private-duty nurse or other private-duty attendant.

* * * * * * *

(c) the term 'inpatient psychiatric hospital services' means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

* * * * * * *

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

Section 1862(a) of the Act provides, in pertinent part:

Notwithstanding any other provisions of this title, no payment may be made under part A . . . for any expenses incurred for items or services—

* * * * * * *

(9) where such expenses are for custodial care. . . .

The general issue to be determined in the instant case is whether or not payment may be made to the hospital on K's behalf for care and services she received while a patient there from November 29, 1968, to January 2, 1969. The answer to this depends on whether the services provided K during this period constituted "inpatient psychiatric hospital services" within the meaning of section 1814(a) of the Social Security Act, or whether they were custodial and supportive in nature and thereby excluded from coverage.

For care and services furnished an inpatient in a psychiatric hospital, to be covered under title XVIII of the Social Security Act, they must constitute active treatment which is reasonably expected to improve the patient's condi-

tion or be for the purpose of diagnosis. In addition, they must be provided under an individualized treatment or plan which is supervised and evaluated by a physician.

The Chairman of the Medical Audit and Utilization Review Committee of the hospital, stated in a letter that by the time K's case was initially reviewed by the utilization review committee on November 27, it was apparent to the attending physician and to the committee that the period of acute treatment could be terminated and domiciliary disposition made.

In the Case Summary and Discharge Note the attending physician stated as follows: "It was felt that she needed time in the hospital to allow us to assess whether her condition would improve with good diet, regular vitamins and tranquilizers, but as time went on her condition seemed to deteriorate. After a six week period of observation, it became quite clear that her condition was such that she would not be able to function outside of an institution and her husband was advised to seek nursing home care."

The doctor's progress notes indicate that as early as October 28, 1968, plans were being considered to remove K from the hospital. Each entry from October 28 through December 24 indicates that K was waiting to be transferred home or to a nursing or rest home. Entries beginning November 4, 1968, indicate that her condition had stabilized.

The facts as presented in the instant case support the conclusion of the attending physician and the utilization review committee on November 27, 1968, "that the period of acute treatment could be terminated and domiciliary disposition made." Although K required and received "active treatment" for a psychiatric disorder during the period from October 18, 1968, through November 28, 1968, the evidence of record indicates that she did not require or receive "active treatment" for a psychiatric disorder after November 28, 1968.

Accordingly it is *held* payment of hospital insurance benefits may not be made on K's behalf for services furnished by the hospital for the period November 29. 1968, through January 2, 1969, because such services were not for the purpose of improving the condition for which she had been receiving psychiatric treatment as required by section 1814(a)(4) of the Social Security Act. Thus, they did not constitute "inpatient psychiatric hospital services" within the meaning of section 1814(a) of the Social Security Act, but were instead custodial in nature and therefore excluded from coverage by section 1862(a)(9) of the Act.

(X—refer to SSR–70–24)

SECTION 1814(d).—HOSPITAL INSURANCE—NONPARTICIPATING HOSPITAL—EMERGENCY SERVICES

20 CFR 405.191 HCFAR–78–9

Where a hospital insurance beneficiary with a chronic arthritic condition is admitted to a hospital eligible for payment under title XVIII of the Social Security Act only for "emergency services," to secure surgical relief for intense pain in her hip, and where there was no medical evidence of a sudden or significant change in her condition, *held*, the hospital is not entitled to payment for the inpatient services it furnished, since such services did not constitute "emergency services" within the meaning of section 1814 of the Act.

R, who is entitled to hospital insurance benefits under title XVIII of the Social Security Act, was admitted to the N Hospital August 22, 1968, because of intense pain in the hip. R had an advanced rheumatoid arthritic condition which had not responded to other treatment, and she underwent hip surgery 2 days after admission. She was discharged on November 1, 1968, based on the physician's statement that the emergency had ceased. A claim for payment pursuant to section 1814(d) of the Act, for the inpatient hospital services furnished R has been made by the N Hospital, a nonparticipating hospital which could claim payment under the program for emergency services only.

Section 1814 of the Social Security Act, as here pertinent, provides:

(d) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements . . . with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services. . . .

The issue to be resolved in this case is whether the inpatient hospital services provided R by the N Hospital constitute emergency services within the meaning of section 1814 of the Social Security Act.

"Emergency services" are defined as those inpatient hospital services which are necessary to prevent death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available, and equipped to furnish such services. A determination as to whether services furnished are "emergency services" will, ordinarily, be based upon the apparent condition of the patient at the time of his arrival at the hospital or upon a physician's conclusions as to his condition following examination of the patient. No payment under the hospital insurance program can be made to a nonparticipating hospital for services furnished after the emergency has ended. Also, hospital services are no longer considered "emergency services" when it is no longer necessary, from a medical standpoint, to care for the patient in a nonparticipating hospital.

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Based on the facts in this case it appears that R had recurring pain in her hip which had defied medical treatment, and the orthopedist believed that surgical therapy was indicated. R's arthritis was becoming progressively worse but there was no indication of any sudden or significant change in her condition which necessitated immediate hospitalization on or about August 22, 1968. R's husband stated that there was a participating hospital which he contacted prior to her admission but it did not have a room available.

The fact that R's husband may have made a preliminary inquiry at a participating hospital and become discouraged when told that his wife could not be admitted in the immediate future does not establish that R could not have been accommodated in a participating hospital. Generally, if a physician recommends hospitalization and surgery, he arranges for the patient's admission to a hospital. There is no evidence that the attending physician attempted to have R admitted to any participating hospital in the immediate area, or that, once the surgery was performed and the pain relieved, there was any attempt to transfer R to a participating hospital.

It has not been established from the above facts that R's admission to the N Hospital was in the nature of an emergency, as defined above, that a hospital participating under title XVIII would not have been available to accommodate her had the physician made the necessary arrangements therefor, or that the N Hospital was the most accessible hospital available equipped to furnish the hospital services required by R.

Therefore it is *held*, R was not furnished "emergency services" within the meaning of section 1814 of the Social Security Act by the N Hospital and accordingly payment cannot be made to the hospital on R's behalf.

(X—refer to SSR–70–26)

SECTION 1814(d).—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—ACUTE MEDICAL CONDITION OCCURRING IN NONPARTICIPATING HOSPITAL SUBSEQUENT TO CESSATION OF ORIGINAL EMERGENCY

20 CFR 405.152 and 405.191 HCFAR–78–10

> Where a hospital insurance beneficiary suffering from a heart attack is admitted to a nonparticipating hospital on an emergency basis and subsequent to the cessation of the acute medical condition for which she was originally hospitalized, she submits to an elective surgical procedure which gives rise to a second acute medical condition, *held*, inpatient hospital services furnished by the nonparticipating hospital for the treatment of the second acute medical condition occurring after the cessation of the initial medical emergency for which she was originally admitted, are not covered emergency inpatient hospital services within the meaning of section 1814(d) of the Social Security Act.

M, a hospital insurance beneficiary, was admitted to a hospital on an emergency basis, suffering from congestive heart failure, pneumonia, and an acute myocardial infarction. The hospital, although not participating as a

provider of services under title XVIII of the Social Security Act, was eligible to receive payment for emergency services pursuant to section 1814 of the Act. After an initial period of treatment, M recovered from the acute medical condition which was the basis for the original emergency admission to the extent that an elective surgical procedure was performed. Following this surgery, M suffered a second myocardial infarction which was severe enough to be considered acute. Payment was made on M's behalf for the care and services provided by the nonparticipating hospital for the original emergency admission pursuant to section 1814(d) of the Social Security Act. However, payment has been denied for the period of hospitalization for the subsequent acute medical condition which occurred some time after cessation of the original medical emergency. M has protested this decision.

Thus, the issue to be resolved in the instant case is whether or not an acute medical condition, which occurred while M was an inpatient in a nonparticipating hospital, following cessation of the emergency condition for which she was originally admitted, comes within the scope of the statutory term "emergency" in section 1814(d) of the Social Security Act.

Section 1814(d) of the Act, which contains the controlling provisions pertaining to coverage of emergency hospital services, provides, as pertinent here, that:

> (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements . . . with it, to an individual entitled to hospital insurance benefits . . . even though such hospital does not have an agreement in effect under this title if (A) such services were *emergency* services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient *emergency* services . . . furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a). (Emphasis supplied.)

Although the language contained in section 1814(d), supra, does not specifically resolve the question posed in the instant case, that is, whether a crisis arising when the patient is *in the hospital* constitutes an emergency, the Senate Finance Committee report (Sen. Rept. No. 404, 89th Congress, 1st Sess. 1965, page 30) provides further guidance thereon, as follows:

> The committee recognizes that there will be emergency situations where an individual who is eligible for hospital insurance benefits will *go or be taken to a hospital* that does not participate in the program. For example, an accident victim might *have to be taken immediately to the nearest* hospital, either for outpatient diagnosis and treatment or for admission as an inpatient. The committee's bill would permit the payment of benefits for emergency hospital diagnostic services or inpatient care in such cases until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution.[1] (Emphasis supplied.)

Although the committee language concerning the transporting of an

[1] See also in this regard H. Rept. No. 213, 89th Cong., 1st Sess. (1965) p. 26.

injured beneficiary to the nearest hospital is illustrative, it must be considered when determining the scope of the definition of the emergency hospital services which are covered under section 1814(d) of the Act. This language also has a bearing on the definition of the term "emergency" because of the parallel reference to emergency hospital services furnished outside the United States which occurs in section 1814(f), as follows:

> *The authority*[2] contained in subsection (d) shall be applicable to *emergency* inpatient hospital services furnished an individual by a hospital located outside the United States if—
>
> (1) such individual was physically present in a place within the United States at the time the *emergency* which necessitated such inpatient hospital services occurred; and
>
> (2) such hospital was *closer to, or substantially more accessible from, such place than the nearest hospital within the United States* which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury. (Emphasis supplied.)

This provision, permitting payment for emergency hospital services furnished outside the United States, was added by the Senate Finance Committee with this observation:

> The Committee has added a provision for emergency services in a hospital outside the United States when it is *closer or substantially more accessible* than comparable facilities in the United States. A further qualification is that the patient has to be physically present within the United Sates when the emergency which necessitated the hospitalization occurred. (Emphasis supplied.)

On the basis of the committee reports there appears to have been a pervasive congressional desire that for emergency hospital services the nearest appropriate hospital facilities be used. This gives rise to the implication that the term "emergency" was intended to refer only to acute medical conditions which occur outside of a hospital and necessitate transportation of the patient to a hospital. This can be seen further in the regulations promulgated by the Secretary of Health, Education, and Welfare for the purpose of facilitating the administration of title XVIII of the Social Security Act. For example, section 405.191 of the Social Security Administration's Regulations No. 5 (20 CFR 405.191) interprets an emergency (for purposes of section 1814(d) of the Act) as a situation occurring outside of a nonparticipating hospital which necessitates transport to such hospital for purposes of admission therein. It states, in pertinent part, that:

> (a) General.—Payment to a nonparticipating hospital for emergency services (as defined in § 405.152 (*b*)) can be made only for the period during which the emergency exists.
>
> (b) Objective.—The objective of paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services only to periods during which the patient's state of injury or disease is such that a *health or life-*

[2] Subsection (d) of section 1814 is entitled: "Payments for Emergency Hospital Services." Thus, this reference to "the authority" which appears in subsection (f) would indicate that not only is the authority to *pay* coextensive between both subsections, but also that the definition of *emergency* is also coextensive.

endangering emergency existed and continued to exist, requiring immediate care which could only be provided in a hospital.

* * * * * * *

(3) *Existence of medical necessity for emergency services is based on the physician's assessment of the patient prior to admission to the hospital. Therefore, conditions developing after a nonemergent admission are not considered emergency services for purposes of this subparagraph.* (Emphasis supplied.)

Thus, the above cited materials clearly contemplate an emergency as being a situation where a person, who is outside of a hospital, requires hospitalization but does not have the ability to choose the particular institution to which he is to be admitted because the medical exigencies relating to his condition require that he be hospitalized immediately. Therefore, an emergency so conceived would not initially arise as the result of those acute or aggravated medical situations or conditions which occur to individuals, either originally or as the result of a previous disease or injury, while such individuals are inpatients in a nonparticipating hospital.

Such a limited concept of emergency is required not only by a technical construction of the Act and the attendant legislative history, but by the general overall philosophy of the Federal Health Insurance for the Aged Act. For example, nonparticipating hospitals which furnish these emergency services are not required to meet all of the section 1861(e) statutory program requirements in order for the emergency services they furnish to be covered services. Such hospitals need only comply with the statutory nursing and State licensing requirements of paragraphs (5) and (7) of section 1861(e).

The emergency inpatient hospital service concept is an exception to the general rule that inpatient hospital services are covered only when furnished in hospitals which fully comply with all of the statutory requirements. This limited exception to program participatory requirements applies only to actual emergency situations where the beneficiary (or his physician) because of supervening medical necessity may not be able to elect to utilize a participating hospital which meets the conditions of high level care required by the Act. This limited exception thus ensures that Medicare beneficiaries will not be disadvantaged by being denied program coverage for essential hospital services furnished in nonparticipating hospitals because of an unexpected acute medical condition suffered by the beneficiary.

The construction of the term "emergency" urged by the claimant would expand the concept of an emergency to include any acute medical conditions occurring to Medicare beneficiaries irrespective of the place of their occurrence.

If the definition of emergency inpatient hospital services were extended by interpretation to include services furnished by nonparticipating hospitals to individuals who entered on a nonemergency basis, or the acute medical conditions arising while there, such nonparticipating hospitals could receive

program payments[3]. Under such circumstances the nonparticipating hospitals might lose their incentive to meet the conditions for participation in the health insurance program[4].

Accordingly, it is *held* that the acute medical condition experienced by M while confined in a nonparticipating hospital on a nonemergency basis after the cessation of the acute medical condition for which she was originally hospitalized is not an emergency within the contemplation of section 1814(d) of the Act. Thus inpatient hospital services furnished in response to a subsequent acute medical condition are not covered as emergency services under title XVIII of the Social Security Act.

(X—refer to SSR–70–48)

SECTIONS 1814 and 1861.—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—CARE AT A FACILITY WHICH DOES NOT MEET THE REQUIREMENTS OF "HOSPITAL"

20 CFR 405.152 and 405.1001(*a*) HCFAR–78–11

After falling at home and lacerating her skull, a 76-year-old hospital insurance beneficiary was taken by ambulance to a hospital owned and operated by her attending physician. It was considered inadvisable to move her due to imminence of a cardiovascular accident. Without regaining consciousness, she died 18 days later. The hospital did not meet the requirements of the definition of "emergency hospital" (it did not have a licensed practical nurse or registered professional nurse on duty at all times and did not provide 24-hour nursing services rendered or supervised by a registered professional nurse). *Held*, payment for the services furnished by the hospital may not be made even though they may have been emergency in nature, since the hospital is not an "emergency hospital" as defined in section 1861(e) and therefore is not a "hospital" for purposes of section 1814(d) of the Social Security Act.

B, a 76-year-old individual entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act, fell in her home, lacerating her skull. She was immediately taken by ambulance to the L Hospital where it was determined a concussion existed. The L Hospital, which does not participate in the health insurance program, is owned and operated by Dr. L, B's attending physician. Dr. L determined that it was inadvisable to move B due to the danger of a cardiovascular accident. Without regaining consciousness, B died 18 days later. Payment for the care and services furnished B has been denied on the basis that the L Hospital does not meet the definition of "hospital" within the meaning of sections 1814 and 1861 of the Social Security Act. B's daughter has protested this determination, stating that payment should be made since the services required by B and furnished by the L Hospital were "emergency" services.

[3] If they have elected to claim payment for all emergency inpatient services furnished during that calendar year. Section 1814(d)(1) of the Act.

[4] The total dollar amounts of these potential payments, both to hospitals and to beneficiaries, cannot be presumed to be insignificant in view of the disproportionately high amount of medical services required by persons over 65.

However, the issue to be resolved is not whether the services were emergency services, but whether or not such services were provided by a "hospital" within the meaning of section 1814(d) of the Social Security Act.

The benefits provided an individual by the hospital insurance program under title XVIII of the Act consist of entitlement to have payment made on his behalf for inpatient hospital services with certain qualifications. One such qualification is contained in section 1814(d) of the Social Security Act which provides, as pertinent here, that:

> (1) Payments shall also be made to any hospital for inpatient hospital services furnished . . . by the hospital . . . to an individual entitled to hospital insurance benefits . . . even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, . . .

Section 1861(e) of the Social Security Act provides, as pertinent here, that the term "hospital" means an institution which:

> (5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
>
> * * * * * * *
>
> (7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;
>
> * * * * * * *
>
> For . . . purposes of section[s] 1814(d) . . . such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, . . . and (iii) is primarily engaged in providing, . . . to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

The facts in the instant case show that the L Hospital is operated by Dr. L in connection with his practice. However, the facility does not have a licensed practical nurse or registered professional nurse on duty at all times and does not provide 24-hour nursing services rendered or supervised by a registered professional nurse. Thus, it is clear that the L Hospital does not meet the requirements contained in section 1861(e)(5) of the Social Security Act.

Accordingly, it is *held*, for purposes of making payment for emergency services, the L Hospital is not a "hospital" within the meaning of section 1814(d) and therefore no payment may be made for the services furnished B while an inpatient there under part A (hospital insurance benefits) of title XVIII of the Social Security Act.

(X—refer to SSR–70–49)

SECTION 1814(a).—HOSPITAL INSURANCE BENEFITS—PSYCHIATRIC HOSPITAL SERVICES—ACTIVE PSYCHIATRIC TREATMENT

HCFAR–78–12

A 68-year-old individual entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act, was admitted as an inpatient to a psychiatric hospital on May 28, 1969, suffering from a psychosis with cerebral arteriosclerosis and diabetes. She received antidepressant and tranquilizing medications beginning May 28 but these medications were discontinued by June 11 and never resumed. A diagnostic study was completed by June 18 at which time it became apparent that her condition had deteriorated beyond the point where any treatment could reasonably be expected to improve her mental condition. *Held*, payment of hospital insurance benefits may not be made for services furnished by the hospital after June 18, 1969, because such services did not constitute covered inpatient psychiatric hospital service within the meaning of section 1814(a) of the Social Security Act, in the absence of "active treatment" for a psychiatric disorder which could reasonably be expected to improve her condition.

H, a 68-year-old hospital insurance beneficiary under part A of title XVIII of the Social Security Act was admitted to the N State Hospital on May 28, 1969. She remained an inpatient of the psychiatric hospital until her death on November 16, 1969. Her admitting diagnosis was a psychosis with cerebral arteriosclerosis and diabetes manifested by an ulcerated foot for which she had previously been hospitalized. Payment was made on H's behalf to the N State Hospital for the services furnished her from May 28, 1969, to June 18, 1969. However, payment has been denied for the remainder of H's stay; i.e., from June 19, 1969, through November 16, 1969, on the basis that the services she received and required in that period did not constitute covered inpatient psychiatric hospital services within the meaning of section 1814(a) of the Social Security Act in the absence of "active treatment" for a psychiatric disorder which could reasonably be expected to improve her condition. H's widower has protested this decision.

The insurance benefits provided an individual under part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including inpatient psychiatric hospital services, for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness. This is subject to the limitation that payment under title XVIII for inpatient psychiatric hospital services is limited to 190 days during an individual's lifetime.

Section 1814(a) of the Act provides, as pertinent here, that payment for services furnished an individual may be made only to providers of service, and only if:

* * * * * * *

(2) a physician certifies (and recertifies . . . with such frequency, and accompanied by such supporting material, . . . as may be provided by regulations, . . .) that

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision

of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

* * * * * * *

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services.

Section 1861 of the Social Security Act provides, as pertinent here, that:

* * * * * * *

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements; excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern and

(5) the services of a private-duty nurse or other private-duty attendant.

* * * * * * *

(c) the term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

* * * * * * *

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons; * * *

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A;

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; * * * *

The issue to be resolved in the instant case is whether or not payment may be made to the N State Hospital on H's behalf for the care and services furnished her while a patient there from June 18, 1969, to November 16, 1969. The answer to this depends on whether the services provided H during that period constituted inpatient psychiatric hospital services within the meaning of section 1814(a)(2)(A) of the Social Security Act.

The basic principle underlying the provisions for coverage of inpatient psychiatric hospital services is that payment is to be made by the program only for "active treatment" which can reasonably be expected to improve the patient's condition or where admission to the hospital and related services provided were necessary for diagnostic study.

The term "active treatment" is defined in a manner designed to reflect and implement the physician certification and the hospital record requirements of section 1814(a) of the Act.

For services in a psychiatric hospital to be designated as "active treatment," they must be: (A) provided under an individualized treatment or diagnostic plan, (B) reasonably expected to improve the patient's condition or for the purpose of diagnosis, and (C) supervised and evaluated by a physician.

The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. Thus, an isolated service, e.g., a single session with a psychiatrist, or a routine laboratory test not furnished under a planned program of therapy or diagnosis would not constitute active treatment, even though the service was therapeutic or diagnostic in nature. The plan of treatment must be recorded in the patient's medical record in accordance with section 405.1037(*a*) (8) of the Regulations on Conditions of Participation for Hospitals.

In addition, the services must reasonably be expected to improve the patient's condition or must be for the purpose of diagnostic study. It is not necessary that a course of therapy have as its goal the restoration of the patient to a level which would permit discharge from the institution although the treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms which necessitated hospitalization *and* improve the patient's level of functioning. The kinds of services which meet these requirements would include not only psychotherapy, drug therapy, and shock therapy, but also such adjunctive therapies as occupational therapy, recreational therapy, and milieu therapy, provided the adjunctive therapeutic services are expected to result in improvement (as defined above) in the patient's condition.

If, however, the only activities prescribed for the patient are primarily diversional in nature, i.e., to provide some social or recreational outlet for the patient, it would not be regarded as treatment to improve the patient's condition. In many large hospitals these adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy (or one of the other adjunctive therapies) is involved, it is particularly important that this therapy be a planned program for the particular patient and not one where life in the hospital is designated as milieu therapy. In accordance with the above definition of "improvement," the administration of antidepressant or tranquilizing drugs which are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definition are met). However, the administration of a drug or drugs does not of itself necessarily constitute active treatment. Thus, the use of mild tranquilizers or sedatives *solely* for the purpose of relieving anxiety or insomnia would not constitute active treatment.

Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. In short, the physician must serve as a source of information and guidance for all members of the therapeutic team who work directly with the patient in various roles. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews—at least once a week. Periodic visits to a patient do not in themselves constitute active treatment.

The fact that a patient is under the supervision of a physician does not necessarily mean that he is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded.

The evidence shows that H did require and receive "active treatment" for a psychiatric disorder during the period from May 28, 1969, through June 18, 1969. However, the evidence of record does not support a conclusion that she required or received "active treatment" for a psychiatric disorder at any time after June 18, 1969. Her physical condition showed a history of diabetes with an ulcer on her left foot. The Doctor's Notes beginning June 5 indicate her physical as well as mental condition showed marked signs of deterioration. Absolute bed rest, I.V. fluids, orange juice and regular insulin injections were ordered on June 12. On June 19 the Doctor's Notes indicate that H's mental condition was unchanged but her physical condition was markedly improved. Her diabetes was under control and she was able to feed herself and participate in the recreational activities in the ward. The Doctor's Notes covering the period June 19 to November 16 indicate that H's physical condition was much improved but that her mental condition was unchanged.

There is no indication in the record that H was given any active psychiatric treatment subsequent to June 18, 1969. The diagnostic study of H was essentially completed by June 18. She had received Tofranil (an antidepressant medication) and Trilafon (a tranquilizing medication) starting on May 28, 1969, but these medications were discontinued on June 11, 1969, and were not resumed. There were no further orders for psychopharmacologic medication after June 11. In fact, the Doctor's Note of August 18 indicates that there was no remarkable change in her mental condition and that she needed "constant supervision and custodial care due to her confusion and gross memory deficit." H did not receive psychotherapy or electroshock therapy and she did not participate in occupational therapy, recreational

therapy or milieu therapy. It was necessary for her to receive supportive care, and she required medication for her diabetic problem, but this could have been provided outside a psychiatric hospital. During the period June 19, 1969, to November 16, 1969, H did not receive individualized psychiatric treatment or the kind of psychiatric services expected to improve her condition.

Hospital insurance benefits are not payable to an inpatient of a psychiatric hospital who is not receiving active psychiatric treatment *unless* the patient is an inpatient of a distinct part of the psychiatric hospital (i.e., a medical-surgical unit) which has been certified for participation as a general hospital and is receiving a level of care which can be covered as inpatient hospital services.

A medical-surgical unit of a psychiatric institution may qualify for participation in the Medicare program as a general hospital independent of the institution as a whole, regardless of whether any other section of the institution is participating in the program. A medical-surgical unit, in order to qualify for participation, must be a separate functioning entity; that is, a distinct and identifiable unit within the institutional complex which is in substantial compliance with all the Conditions of Participation for Hospitals. Such a unit must be designed for the purpose of providing treatment for conditions other than mental illness.

The N State Hospital is certified for participation in the Medicare program as a psychiatric hospital but does not have a certification of a distinct part as a medical-surgical unit in which general hospital services would be covered. Consequently, the services rendered H in the N State Hospital would have to constitute "active treatment" in a psychiatric hospital, to be covered under title XVIII of the Social Security Act.

Accordingly, it is *held*, payment of hospital insurance benefits may not be made on H's behalf for services furnished by the N State Hospital after June 18, 1969, because such services were not "active treatment" for the purpose of improving the conditions for which she had been receiving psychiatric treatment, as required by section 1814(a)(4) of the Social Security Act.

(X—refer to SSR–70–58)

SECTIONS 1814(d) and 1866(a).—HOSPITAL INSURANCE BENEFITS —NONPARTICIPATING HOSPITAL—EMERGENCY SERVICES

20 CFR 405.152 HCFAR–78–13

Where a nonparticipating hospital, qualified to furnish emergency services, furnished services to a beneficiary upon a physician's supporting statement that a medical emergency existed, but the evidence failed to establish that the condition of the beneficiary at the time of admission was such as to require emergency services, as that term is defined in section 1814 of the Act, *held*, the services did not constitute emergency services within the meaning of section 1814 and accordingly, no payment may be made to the hospital for the services furnished.

R, a 90-year old woman entitled to hospital insurance benefits under the Social Security Act, awoke immobile on March 27, 1967, with acute back and kidney pains. Her daughter in a nearby town and her physician were notified and arrangements were made to transport R by auto to the family physician 12 miles away. However, before departure the daughter performed several personal errands, bathed and dressed R, and assembled her personal belongings. Upon arrival, R waited her turn in the doctor's office; then, after an examination and completion of laboratory tests, the physician immediately ordered R to the M Hospital, a local nonparticipating hospital, as an emergency patient. She was admitted at 4:15 P.M. as a Medicare emergency upon a supporting statement by the physician as to R's severe chest and back pains. However, all findings on her physical examination by the admitting physician at the hospital, some 7½ hours after initial complaint, were negative, normal, unremarkable, except for her carcinoma and chronic pyelonephritis, conditions for which she had been treated some time earlier at the X Clinic. R was discharged from the M Hospital on May 12, 1967. A bladder tumor was discovered some three weeks later; however, R did not enter the X Clinic for treatment until October 1967. She died November 3, 1967. The M Hospital applied for payment for emergency hospital services, furnished to R, pursuant to section 1814(d) of the Act.

Section 1814(d) of the Act provides in pertinent part:

> (d) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements * * * with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and * * *.

Further provision for reimbursement for services provided by a nonparticipating hospital furnishing emergency services, is made by section 405.152 of Social Security Administration Regulations No. 5 (20 CFR 405.152), which provides, in part, as follows:

> (a) Payment * * * may be made to a hospital even though the hospital is not a participating provider (i.e., it has not entered into an agreement with the Secretary, pursuant to section 1866 of the Act * * *) if:
>
> (1) The hospital meets the requirements of section 1861 (e) (5) and (7) of the Act * * *, and; * * *
>
> (2) The services furnished are emergency services (see paragraph (b) of this section) furnishd an individual who meets the requirements of § 405.102;
>
> * * * * * * *
>
> (b) For purposes of the hospital insurance benefits program, "emergency services" are those inpatient hospital services * * * which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital * * * available and equipped to furnish such services. * * *

The issue presented is whether the services rendered to R by the M Hospital were emergency services for which payment would be required under section 1814(d) of the Act.

On the basis of the above presented facts, R's hospital admission failed to reflect an emergency by any standard. The statement by an attending physician, unless supported by medical or clinical evidence, will not support a contention that a medical emergency existed. In this case, no ambulance was immediately summoned to the house. R was taken by auto to the doctor, awaited her turn in his office, and was admitted to the hospital some 7½ hours after the onset of her pains. The hospital records contained no indication of emergency or nearness of death, and in fact showed that R's condition continued to improve after the second day. R's carcinoma was known, proven, diagnosed and had been treated at the X Clinic and by the family physician. Her pyelonephritis condition was chronic; the discovery of a bladder tumor some weeks after the hospital admission appears not directly related to any medical emergency.

The M Hospital admission records indicated only mild distress. Since R had previously been treated in the X Clinic for carcinoma, we may assume that she would have been referred there again for any acute complications of the disease. The fact that a person becomes progressively debilitated because of a neoplastic disease does not establish the existence of an emergency for hospital reimbursement purposes.

Accordingly, it is *held* that the inpatient hospital services furnished R during the period March 27, 1967, through May 12, 1967, do not constitute "emergency services" within the meaning of section 1814 of the Act; therefore, payment cannot be made on R's behalf to the nonparticipating M Hospital.

(X—refer to SSR–71–9)

SECTIONS 1812(a) and 1814(a) (2) (D).—HOSPITAL INSURANCE BENEFITS—POST-HOSPITAL HOME HEALTH SERVICES—HOME CONFINEMENT REQUIREMENT

20 CFR 405.170(b) (1) HCFAR–78–14

Where a hospital insurance beneficiary requires skilled nursing care in the form of hypodermic injections of psycho-therapeutic drugs to keep her under sedation at all times because of psychoneurosis, displaying continuous symptoms of anxiety reaction with severe depression and such injections are furnished in her home by a home health agency pursuant to a doctor's orders for the treatment of a condition for which she had been an inpatient in a hospital and to leave her home to secure such injections is medically contraindicated, *held*, the beneficiary is home confined for purposes of section 405.170(*b*) (1) of Regulations No. 5 of the Social Security Administration and, therefore, the skilled services furnished her by the home health agency constitute post-hospital home health services within the meaning of section 1814(a) (2) (D) of the Social Security Act of which payment may be made under part A of title XVIII of the Act.

Immediately following the last of several periods of hospitalization during 1969, L, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act, required skilled nursing care in the form of hypodermic injections for a nervous condition. These injections were administered to L in

her home pursuant to a plan established by her physician by a nurse from the X Visiting Nurses Association, certified as a provider of services under title XVIII of the Social Security Act. L was discharged from the hospital on August 5, 1969, and the skilled services of the X Visiting Nurses Association were required beginning August 7 and ending October 26, 1969. Altogether, L received 49 administrations of medication by use of a hypodermic injection, each of which was administered by a nurse who came to her home.

A claim for payment has been filed on L's behalf by the Nurses Association under Part A hospital insurance for the services furnished her for the period August 7 to October 26, 1969. Thus, the issue to be determined is whether the services furnished L constitute post-hospital home health services as defined in section 1814(a) (2) (D) of the Act. This turns on whether or not L's condition required that she be home confined within the meaning of section 405.170(*b*) (1) of Regulations No. 5 of the Social Security Administration (20 CFR 405.170(b) (1)).

Section 1812(a) of the Social Security Act provides, as pertinent here, that:

> The benefits provided to an individual by the insurance program under this part [part A hospital insurance] shall consist of entitlement to have payment made on his behalf . . . for—
>
> * * * * * * *
>
> (3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.

Section 1814(a) of the Social Security Act provides, as pertinent here, that payment for services furnished an individual may be made only to providers of services, and only if—

> (2) a physician certifies (and recertifies, . . . with such frequency, and accompanied by such supporting material, . . . as may be provided by regulations, . . .) that—
>
> (D) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home . . . and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services . . .; [and] a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; * * * *

L's attending physician, in describing her condition, stated that she had a mental depression and that she has for many years been under the care of physchiatrists and has taken practically all of the psychotherapeutic drugs at one time or another. He stated that she had to be kept under continuous and rather potent sedation at all times and that because of this medication with psycho-therapeutic drugs, she was unable to be out and unable to make calls at a doctor's office. At times when the condition was more acute, she had a number of hospital admissions. The doctor stated that when at home it was necessary for her to receive hypodermic injections of the psycho-therapeutic drug Talwin; he also stated that he was not in the position because of time limita-

tions to administer these. He believed it was necessary that a visiting nurse be utilized to give the medication until October 29, 1969, when her condition showed some improvement and Talwin could then be administered to her orally.

The nurses' notes made at each of the visits between August 7 and October 26, 1969, describe L as appearing very agitated, very nervous, needing assistance to return to bed; being very miserable, having a far away look and being nervous; being curled-up and holding on to her abdomen, having had a bad day; being uncomfortable, and having pain in the abdomen, etc.

Based on the evidence of record, it is clear that for L to leave her home even with the aid of another person to visit the doctor or for other occasional short periods requires considerable effort and appears to be medically contraindicated. The injections which were given to L required the skilled services of either a nurse or doctor, and this medication could be safely administered in her home without endangering her health.

Accordingly, it is *held*, L was home confined due to her condition as required by section 405.170(b) (1) of Regulations No. 5 of the Social Security Administration and thus the skilled services furnished her from August 7, 1969, to October 26, 1969, constitute post-hospital home health services within the meaning of section 1814(a) (2) (D) of the Act for which payment may be made.

(X—refer to SSR–71–17)

SECTION 1862.—HOSPITAL INSURANCE BENEFITS—LEVEL OF HOSPITAL CARE—CUSTODIAL CARE EXCLUSION

20 CFR 405.116 and 405.310(g) HCFAR–78–15

A diabetic individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act is readmitted to the hospital because his wife is hospitalized and there is no one else to assist him in his daily activities at home, or in the administration of the insulin he requires daily. *Held*, payment may not be made on his behalf to the hospital for the services furnished him because the primary purpose of his care was not to provide him with skilled services generally furnished by a hospital but rather to provide essentially custodial and supportive care, which is specifically excluded from coverage by section 1862(a) (9) of the Act.

Y, an individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, had been hospitalized with a diagnosis of diabetes and generalized arteriosclerosis. A month after his discharge from the hospital, he was readmitted primarily because his wife was also hospitalized and he could not take care of himself at home, since he was a double amputee. A claim has been filed for payment on Y's behalf for the services furnished him by the hospital beginning May 5 and ending June 25, 1969.

The hospital insurance program under title XVIII of the Act provides for payment to the hospital, on behalf of an individual for health services, subject to certain exclusions and limitations contained in the Act. One such exclusion, contained in section 1862(a) of the Act, states that:

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

* * * * * * *

(9) where such expenses are for custodial care;

* * * * * * *

The issue to be decided in this case therefore is whether the services furnished Y by the hospital from May 5 to June 25, 1969, constitute covered inpatient hospital services or whether such services are precluded from coverage by the "custodial care exclusion" in section 1862(a)(9) of the Act.

The facts show that Y was hospitalized not because he needed to be in a hospital, but rather because he was unable to conduct the activities of normal existence such as personal hygeine, getting in and out of bed, etc., by himself. His wife also was hospitalized, and no one could be found to work in his home and take care of him. As a diabetic, he needed periodic injections of insulin which had to be administered by another, since he was unable to do so himself.

Payment may not be made under title XVIII for the cost of inpatient hospital services if the *primary* purpose is to provide custodial care; that is, care designed essentially to assist an individual to meet his activities of daily living. These are services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication (including injections) which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel.

The claimant required and received services which were primarily supportive or custodial in nature and thus are excluded from coverage under section 1862(a)(9) of the Social Security Act. Accordingly, it is *held* that payment may not be made on Y's behalf to the hospital for the services provided him during the period beginning May 5 and ending June 25, 1969.

(X—refer to SSR–71–19)

SECTION 1862(a)(9).—HOSPITAL INSURANCE BENEFITS—LEVEL OF CARE IN HOSPITAL—CUSTODIAL CARE EXCLUSION

20 CFR 405.310(g) HCFAR–78–16

A hospital insurance beneficiary was admitted to the hospital on January 9, 1969, in a state of mental confusion with diagnoses of arteriosclerosis, heart disease, anemia, and senility. She required digitalis and bedrest until January 16 when she was allowed out of bed to sit in a chair and walk to the bathroom. By January 26 she could walk unaided and was well oriented. By January 31 her physician considered that she was "really much better" and nursing home arrangements were being made. However, such transfer was not made until March 3. *Held*, payment of hospital insurance benefits may not be made on her behalf for the period February 1 through March 3, since the primary purpose of the care furnished by the hospital was to assist her in meeting the activities of daily living which is custodial and specifically excluded from coverage by section 1862(a)(9) of the Act.

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F, a hospital insurance beneficiary under part A of title XVIII of the Social Security Act, was an inpatient of the T Hospital from January 9, 1969, until March 3, 1969, with diagnoses of arteriosclerosis, heart disease, anemia, and senility. Payment of hospital insurance benefits has been made on F's behalf to the T Hospital for the services furnished her from January 9 to February 1. However, payment has been denied for the remainder of F's hospital confinement (i.e., after February 1) on the ground that the services required and received were custodial and therefore excluded from coverage by section 1862(a) (9) of the Social Security Act. F's son, acting on her behalf, protested this decision.

The benefits provided an individual by the health insurance program under title XVIII of the Act, including parts A and B, consist of entitlement to payment for health and medical services, subject to specified exclusions and limitations contained in the Act. One such exclusion, contained in section 1862(a) of the Act, provides that:

> Notwithstanding any other provision of this title, no payment may be made under part A or part B [supplementary medical insurance] . . . for items or services—
>
> * * * * * * *
>
> (9) where such expenses are for custodial care;
>
> * * * * * * *

Thus, the issue to be resolved in the instant case is whether the services furnished F by the T Hospital from February 1 to March 3 constitute covered inpatient hospital services or whether such services are custodial and, therefore, expressly excluded by the "custodial care exclusion" contained in section 1862(a) (9) of the Social Security Act.

Evidence in the form of hospital notes shows that upon admission F's condition was characterized as "mental confusion, breathlessness, frequent falls." She was confined to bed and received a daily dose of digitalis. The doctor's notes and the hospital record reveal that beginning January 12 F's condition steadily improved. By January 16 she was allowed to use the bathroom and sit in a chair and appeared well oriented. By January 26 her condition had improved to the point that she was able to walk unaided. The doctor noted on January 31: "Really much better—nursing home arrangements are being made." On February 2 the doctor noted that a particular nursing home was being considered and noted: "General condition unbelievably improved." Thereafter, the hospital record as well as the doctor's notes indicate that it was taking considerable time to decide to which nursing home F would go.

Payment of hospital insurance benefits may not be made under title XVIII of the Social Security Act for the cost of inpatient hospital services if the primary purpose is to provide custodial care; that is, care designed to assist an individual in meeting the activities of daily living. These are services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered

and which does not entail or require continuing attention of trained medical or paramedical personnel.

The evidence indicates that the services required and received by F after February 1 and until her discharge on March 3 were custodial. Accordingly, it is *held* that payment may not be made on F's behalf to the T Hospital because such services were custodial and specifically excluded by section 1862(a) (9) of the Act.

(X—refer to SSR–71–27)

SECTIONS 1813(a)(3) and 1869(b).—HOSPITAL INSURANCE BENEFITS—RIGHT TO A HEARING—AMOUNT IN CONTROVERSY

HCFAR–78–17

A claimant for hospital insurance benefits was provided post-hospital extended care services. He appealed the denial of his request for payment and filed a request for hearing. *Held*, since the amount at issue is less than $100, there is no right to a hearing under section 1869(b) of the Act; therefore, the reconsidered determination, which affirmed the denial of payment, became the final decision of the Secretary.

H, following 5 days' hospitalization as an inpatient, was transferred on June 26, 1969, to a participating extended care facility. Payment was authorized for the services rendered him during the period June 26, 1969, through August 26, 1969, but was denied for the ensuing 15-day period ending September 11, 1969, the charges for which amounted to $180. The daily coinsurance amount under applicable law at such time was $5.50 for a total of $82.50. Upon reconsideration, the denial of his claim was affirmed on February 4, 1970. From this reconsidered determination H filed a request for a hearing on March 23, 1970.

The issue thus raised is whether the claimant is entitled to a hearing. This, in turn, depends on whether the "matter in controversy" is $100 or more within the meaning of section 1869(b) of the Social Security Act.

Section 1869(b) of the Act provides, in pertinent part, that:

> Any individual dissatisfied with any determination * * * as to entitlement under part A or part B, or as to amount of benefits under part A where the amount in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) * * * *.

Furthermore, with respect to cost sharing or coinsurance for hospital and post-hospital services, section 1813(a) of the Act provides, in part:

> (3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

The Secretary of Health, Education, and Welfare, pursuant to the authority vested in him under section 1813(b) (2) of the Act, established and promulgated as the inpatient hospital deductible applicable to a spell of illness occurring in 1969, the amount of $44. Thus the daily coinsurance amount for this

claim is $5.50.

After deducting the daily coinsurance amount here applicable, the amount at issue is $97.50 ($180 minus $82.50). Since this is less than $100 prescribed by law, there is no right to a hearing under section 1869(b) of the Act, as amended. Accordingly, it is *held* that the reconsidered determination of February 4, 1970, is the final decision of the Secretary.

(X—refer to SSR–71–47)

SECTION 1814(d) (42 U.S.C. 1395ff).—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—INPATIENT OF NONPARTICIPATING HOSPITAL FOLLOWING TERMINATION OF THE EMERGENCY PERIOD

20 CFR 405.152(b), 405.191–2 HCFAR–78–18

Where a hospital insurance beneficiary with congestive heart failure was admitted on January 15 to a hospital eligible for payment under title XVIII of the Social Security Act only for "emergency services," and remained there until her condition improved so that beginning January 18 she could have been transferred to a participating hospital without endangering her health, *held*, payment may be made to the hospital for the services furnished from January 15 through January 17 since such services constitute "emergency services" within the meaning of section 1814(d) of the Social Security Act. *Further held*, payment for the services provided after January 17 is precluded since the services did not constitute "emergency services" once her condition improved to the point where she could have been transferred to a participating hospital.

K, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act, entered the O Hospital on January 15 with an admitting diagnosis of arteriosclerotic heart disease with congestive heart failure. On January 23, K was discharged from the O Hospital which, although not participating as a provider of services under title XVIII of the Social Security Act, was eligible to receive payment for emergency services pursuant to section 1814(d) of the Act. A claim was filed for reimbursement for the services furnished K by the O Hospital from January 15 through January 23. Payment has been made only for the period January 15 through January 17 but has been denied for the remainder of the period, i.e., January 18 through January 23, on the grounds that K's emergency terminated January 17 and thereafter she could have been transferred to a participating hospital. K protested this decision; it was contended on her behalf that the Social Security Administration erred in relying on its regulations published after her discharge from the hospital to make a determination in her case.

Section 1814(d) of the Social Security Act provides, as pertinent here, that payment for inpatient hospital services furnished an individual may be made to providers of services who, by agreement with the Secretary of Health, Education, and Welfare, are eligible to participate in the Medicare program under title XVIII of the Act. Payment will also be made to or on behalf of an indi-

vidual, upon a claim for reimbursement, for inpatient hospital services furnished even though such hospital is not a fully participating provider under title XVIII, if among other requirements, the services were emergency services.

Section 405.152(*b*) of Social Security Administration Regulations No. 5 (20 CFR 405.152(b)), as pertinent here, defines "emergency services" as those inpatient hospital services which are necessary to prevent death or serious impairment to the health of an individual and which, because of the threat to the life or health of an individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

Section 405.192 of Regulations No. 5 (20 CFR 405.192) provides, in pertinent part:

> (a) General.—Services, to be emergency services (as defined in section 405.152(b)), must be furnished by the most accessible hospital available and equipped to furnish such services.
>
> (b) Objectives.—The objective of the requirement in paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services provided by nonparticipating hospitals to situations where transport of the patient to a participating hospital would have been medically inadvisable, e.g., the participating hospital would have taken longer to reach and the patient's condition necessitated immediate admission for hospital services; and for so long as that condition precluded the patient's discharge or removal to a participating hospital.

Section 405.191 of Regulations No. 5 (20 CFR 405.191) states, in pertinent part:

> (a) General.—Payment to a nonparticipating hospital for emergency services (as defined in section 405.152(b)) can be made only for the period during which the emergency exists.
>
> * * * * * * *
>
> (2) An emergency no longer exists when it becomes safe from a medical standpoint to move the individual to a participating hospital or other institution, or to discharge him.

The issue to be determined in this case is whether payment of hospital insurance benefits may be made for the services K received from the O Hospital for the period January 15 through January 23. The answer to this depends upon whether the services were emergency services within the meaning of section 1814(d) of the Social Security Act and regulations promulgated thereunder. In addition, assuming the facts show that an emergency existed upon K's admission to the hospital, it must be resolved whether such emergency continued for the entire period of her confinement beginning January 15 and ending with her discharge on January 23.

The medical evidence shows that K's condition upon admission to the O Hospital on January 15 required emergency inpatient hospital services to prevent death or serious impairment to her health. However, the hospital records further show that by January 17 her condition had improved to the point where emergency services were no longer necessary and she could have been transferred to a participating hospital without danger to her health.

Although section 405.192 (20 CFR 405.192) of Regulations No. 5, the pertinent provisions of the regulations, were not published in the Federal Reg-

ister until July 3, after K's inpatient hospital stay, they became effective upon publication and are applicable to any case decided after that date, regardless of the day of hospital admission, the date on which the claim was filed, or the period for which the services were provided, since they constitute a clarification of what had already been provided in the Social Security Act.

Accordingly, *held*, payment may be made on K's behalf to the O Hospital for the services furnished her from January 15 through January 17 since such services constituted "emergency services" within the meaning of section 1814(d) of the Social Security Act. *Further held*, payment is denied for the remainder of K's inpatient hospital stay, i.e., from January 18 through January 23, since the services did not constitute "emergency services" once her condition improved to the point where she could have been transferred to a participating hospital.

(X—refer to SSR–71–56)

SECTION 1866.—TERMINATION OF PROVIDER'S AGREEMENT—WITHHOLDING A SEGMENT OF SERVICES FROM TITLE XVIII MEDICARE PATIENTS

HCFAR–78–19

A provider of health services participating under a title XVIII agreement—whether it is a hospital, extended care facility, home health agency, or other health care facility—withholding a segment of its services which are ordinarily furnished to all patients generally, from patients who are Medicare beneficiaries, *held* in possible violation of its participation agreement, justifying termination thereof by the Secretary of Health, Education, and Welfare.

A question has been raised whether refusal by a provider of health services participating as such under section 1866 of the Social Security Act, to provide Medicare patients with a segment of services which are ordinarily furnished by the provider to its patients generally, constitutes a breach of the provider's participation agreement. In one instance the provider, a home health agency, wished to adopt a policy whereby it would not accept medical insurance (Part B) enrollees for home health treatment plans; in another, a provider hospital wished to adopt a policy whereby it would restrict its outpatient physical therapy services to patients who were not Medicare beneficiaries.

An institution or organization which qualifies as a provider of services under section 1861 of the Act may participate and become eligible for payment under the title XVIII health insurance program if it files an agreement with the Secretary pursuant to section 1866(a)(1) of the Act. The provisions of this section pertain equally to provider services under Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Subsection (b) provides, as pertinent here, that the agreement may be terminated by the Secretary if he determines that:

> . . . (A) such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861 . . . .

When a home health agency agrees to participate in the program, the agreement commits the agency to participate fully and not just in those situations where it is convenient or expedient to do so. The provisions of section 1866(a)(1) of the Act pertain equally to provider services under Part A and Part B, and refusal by the agency to treat Part B enrollees constitutes a breach of its section 1866 agreement to participate in the title XVIII program. There might be a valid explanation in an individual case, but a general policy of refusing services covered only under Part B is not acceptable. For example, in the absence of a general policy applicable to all patients, Medicare and non-Medicare, a hospital-based home health agency may not properly limit its services to Part A post-hospital patients and thereby exclude all Part B enrollees who had not had prior hospitalization. Home health services are defined in section 1861(m) of the Act and are identical under Part A and Part B.

An agency does not provide Part A or Part B home health services, it provides simply—home health services. A beneficiary may be entitled to coverage under Part A or Part B or both, but the home health services furnished to him are the same services regardless of whether they are covered under Part A or Part B. As stated in section 1861(m):

> The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan * * * established and periodically reviewed by a physician, which items and services are . . . provided on a visiting basis in a place of residence used as such individual's home—* * *.

Since there is no distinction between Part A and Part B in the statutory definition of home health services, this practice would be a discrimination within the title XVIII program for which there is no suitable explanation or rationale. An agency policy of restricting services to Part A post-hospital patients would not, in the absence of a general policy applicable to all patients, Medicare and non-Medicare, be a sufficient justification for excluding Part B enrollees because home health services are covered under Part B after the individual has exhausted his Part A entitlement to post-hospital home health services. Thus, the status of an individual at the time when he receives services is determined by factors wholly unrelated to the reservations granted to a provider in section 1801 of the Act to operate free from supervision or control over the manner in which services are provided or over its administration and operation. Whether payment is under Part A or Part B is determined by operation of the Act and the agreement of the provider filed pursuant thereto, taking into account such factors as the limit on utilization under Part A or the requirement of prior hospitalization. Neither of these factors bears on the selection of Medicare patients by the provider.

For example, if a beneficiary is found, even after the rendition of home health services by a home health agency, to have exhausted his 100 visits by virtue of the receipt of earlier visits within the year from another agency, the second agency can be paid under Part B for only 80 percent of the cost of the subsequent visits, subject to the annual deductible, and, further, is

required to accept such payment under the program. The coverage of home health services under either part of title XVIII thus bears no relation to a process of Medicare patient selection or rejection by a provider which may only be in conformity with the provider's commitment to accept payment for covered services in accordance with section 1866(a)(1) of the Act.

If adopted, such a policy would appear to be a subterfuge to circumvent the agency's commitment under its section 1866 agreement. The gist of the provider agreement is to participate under title XVIII, not just Part A of title XVIII. As stated in section 1866(a)(1): "Any provider of services shall be qualified to participate *under this title* and shall be eligible for payments *under this title* if it files with the Secretary an agreement—* * *." (Emphasis supplied.) Admittedly, for example, it would be easier for a provider not to be bothered with deductibles and coinsurance under Part B, but these considerations are not valid grounds for discriminating against Part B enrollees. If a substantial number of home health agencies were to adopt such a procedure, the value of the Part B benefit would be significantly reduced.

In summary, if a home health agency provides and is reimbursed for services under Part A it cannot, in the absence of a general policy applicable to all patients, Medicare and non-Medicare, refuse to provide services under Part B. Failure to do so should be regarded as a violation of the provider agreement, which if not corrected, would justify a termination action by the Secretary.

In the second situation, the provider is a participating hospital which wishes to adopt a policy of restricting outpatient physical therapy services to non-Medicare patients. For the following reasons, this is also in violation of its participation agreement which would support a termination action by the Secretary under section 1866(b)(2) of the Act cited above.

The term "hospital" for purposes of the Medicare program, is defined in section 1861(e) of the Act. As the term is defined therein, the institution must establish that it meets certain specified criteria of service furnished uniformly to *all* patients. For example, under section 1861(e)(2) the "hospital" must maintain clinical records on *all* patients. Paragraph 4 of the definition, moreover, requires that every patient must be under the care of the physician, and paragraph 5 sets forth the requirement for round-the-clock nursing services available to the patients of the hospital without exception. An institution, therefore, which withholds some segment of its services from a class of patients it has accepted for care and treatment would fail to meet the definition of the term "hospital."

This point is more clearly demonstrable by reference to the definition of "inpatient hospital services" in section 1861(b)(2) of the Act, wherein it is stated that "inpatient hospital services" includes "such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients * * *." The conclusion must be drawn from the foregoing, in accordance with its exact terms, that an institution which discriminates among its inpatients with regard to the

services which constitute inpatient hospital services, would not be providing services as contemplated by the law and, therefore, would be unable to meet the definitional requirement in section 1861(e)(1) of the Act. While the fact pattern here pertains to outpatient physical therapy services, the principle applies with equal force to inpatients and outpatients of a provider of services. No Medicare patient may have withheld from him services ordinarily provided by the health care institution to its patients generally if the institution is to qualify or remain qualified as a provider of services.

(X—refer to SSR–72–38)

SECTION 1866(a).—HOSPITAL INSURANCE BENEFITS—PROVIDER AGREEMENT NOT TO CHARGE FOR COVERED SERVICES—EFFECT OF LIFE-CARE CONTRACT WITH HOME FOR THE AGED

20 CFR 405.607 HCFAR–78–20

Where a Home for the Aged is obligated under the terms of its "life-care" contracts with residents, by virtue of the residents' payment of "life-care" fees, to provide them medical services covered under title XVIII, without additional charge, *held* the Home is precluded from entering into a valid participation agreement under section 1866(a) of the Social Security Act. *Further held*, if the life-care contract excludes such covered services from the services the Home obligates itself to provide without charge to residents, the Home may participate in the title XVIII program, provided it otherwise meets prescribed standards.

The B Home for the Aged, a nonprofit corporation, furnishes nursing services to its residents in its own nursing unit, which meets standards prescribed under title XVIII of the Social Security Act for participation in the health insurance program (Medicare) as an extended care facility. Advice has been asked whether the B Home, considering the financial arrangements made with its residents, can enter into a valid agreement under section 1866(a) of the Act for its nursing unit to participate in that program.

Each individual applying for admission as a resident is required to sign a "life-care" contract with the Home under which he agrees to pay a stipulated sum on admission, plus a specified monthly amount until his death or other termination of residence. In return, the Home agrees to provide or pay for stipulated lodging, facilities and services, including specified physician, hospital and skilled nursing services as needed, without additional charge to the individual.

Section 1866(a) of the Act provides, in pertinent part, that for an extended care facility or other provider of services to participate under the Medicare program, it must file with the Secretary of the Department of Health, Education, and Welfare an agreement not to charge any individual (other than applicable deductible and coinsurance amounts) for items and services it furnishes for which such individual is entitled to have payment made under title XVIII. The insurance benefits provided an individual under this title of the Act include entitlement of the Medicare beneficiary to have payment made on his behalf to a participating extended care facility

for post-hospital extended care services up to 100 days during any spell of illness.

The B Home's nursing unit furnishes residents of the Home nursing care, bed and board in connection with such care, and certain related services covered as post-hospital extended care services under title XVIII. By virtue of the "life-care" contracts, the Home has been charging and receiving life-care fees. A certain portion of these fees is prepayment by the resident for the same post-hospital extended care services which are covered under title XVIII, and for which the Home would claim payment as a provider.

Thus, the terms of the B Home's "life-care" contract with its residents prevent the Home from complying with the terms of the agreement required by section 1866(a) of the Act. Therefore, it is *held* that the B Home cannot enter into a valid participation agreement and hence cannot participate in the title XVIII health insurance program.

If, on the other hand, a "life-care" contract does, either expressly or by clear implication, exclude from the services which the Home must provide to its residents without charge, services for which payment may be made under Medicare, then the Home is not obligated to provide those services without further payment. In that event the contract would not prevent the Home from complying with the terms of the participation agreement provided for in section 1866(a) of the Act.

(X—refer to SSR–72–39)

SECTION 1866.—PROVIDER PARTICIPATION AGREEMENT—REQUIREMENT TO SUBMIT ANNUAL COST ACCOUNTING REPORT—ADJUSTMENT OF INTERIM PAYMENTS

20 CFR 405.406, 405.454, 405.614 HCFAR–78–21

Failure by a participating provider of services in receipt of interim program payments based on estimated costs to file the annual cost reports required by section 1866 of the Social Security Act and regulations thereunder for the proper determination of reimbursable cost amounts for services it furnished to Medicare beneficiaries, notwithstanding it had been repeatedly advised of the necessity for, and due dates of, such reports, *held*, ample justification for termination by the Administration of the provider's participation agreement under section 1866 of the Act.

An institution or organization which qualifies as a provider of health or medical services under title XVIII of the Social Security Act may be eligible to receive payments for such services if it has filed a participation agreement with the Secretary of the Department of Health, Education, and Welfare pursuant to section 1866 of the Act. The V Nursing Home entered into a section 1866 participation agreement in October 1967, and payments of approximately $70,000 were made to it through March 1969. The Home was notified that its participation agreement would be terminated as of May 30, 1970, because it had failed to file annual cost reports for any of the operating years, 1967, 1968, and 1969, as required by section 405.406(b) of Regulations No. 5 of the Social Security Administration (20 CFR

405.406), with the result that no further payments would be made to the Home thereafter. While not denying that it failed to file annual cost reports for those years, the V Nursing Home has protested termination of its participation agreement, on the ground of special circumstances which prevented it from filing the annual reports timely.

The issue to be resolved in this case is whether the Social Security Administration was justified in taking such termination action because of failure by the V Home to file the annual cost reports required by section 1866 of the Act and regulations thereunder.

As pertinent here, section 1866(b) of the Act provides that any agreement with a provider of services may be terminated:

> (2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or . . . (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, . . .

Section 405.406 of Regulations No. 5, cited supra, spells out the extent of the financial records and statistical data which participating providers must, under principles of cost reimbursement, maintain for proper determination of costs payable under the program. Standardized definitions, accounting, statistics and reporting practices which are widely accepted in the hospital and related fields are followed by the Administration. Subsection (b) provides that:

> "Cost reports will be required from providers on an annual basis with reporting periods based on the provider's accounting year . . . ."

The facts, which are not in dispute, show that the fiscal intermediary arranged for meetings to explain to the V Home implementation of the extended care portion of the program, furnished the Home information about reimbursement, as well as the rules and regulations governing the filing of cost accounting reports. In February 1969, the V Home was advised by the fiscal intermediary, acting on behalf of the Social Security Administration, that its cost report for 1967, which should have been filed prior to April 1, 1968, was delinquent. At that time the Home was reminded that a report for the fiscal year ended December 31, 1968, should be filed prior to April 1, 1969. The Home was also advised that the Administration was then contemplating termination of the Home's section 1866 agreement, unless it filed its delinquent cost reports prior to April 1, 1969.

The V Home stated it was aware of the due dates of the cost accounting reports, but complained that it could not find an accounting firm capable of handling its books. The officials also contended that the IRS had held its books for the first 3 months of 1970, as a reason for failure to file the 1969 reports timely. On May 1, 1970, the Administration notified the Home that, because of its continued failure to file the required annual cost reports, the section 1866 participation agreement was terminated as of May 30, 1970. Public notice of this termination was made in the local press on May 21, 1970, advising the public that Medicare payment would not be

made for extended care services furnished to patients admitted to the V Home on or after May 30, 1970.

The required filing of annual cost accounting reports by participating providers of services under Medicare permits the Government to make fair and equitable payment for the services furnished to Medicare beneficiaries commensurate with current costs to the individual provider. Fiscal intermediaries establish a basis for interim payments to each provider, using any one of several methods. Where an intermediary is already paying the provider on a cost basis, the intermediary can adjust its rate of payment to an estimate of the result under title XVIII principles of reimbursement. Where no organization is paying the provider on a cost basis, the intermediary can obtain the previous year's financial statement from the provider and by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may then be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs.

At the end of the period, the actual apportionment, based on the cost-finding and apportionment methods selected by the provider, will determine the reimbursement for the actual services provided to beneficiaries during the period. Basically, therefore, interim payments to providers will be made throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible; the retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than an estimated basis. The requirement to file annual reports permits such interim payments to each provider where required. It also makes it easier to take into account cost increases as they actually occur. Where, as in this case, interim payments have been made to the provider on an estimated cost basis, cost accounting reports will help assure that the interim payments approximate actual costs as nearly as practicable, so that retroactive adjustment based on actual costs will be as small as possible.

The V Nursing Home failed to comply with section 1866 of the Act and pertinent regulations of the Administration cited above, which required it to file annual cost accounting reports for the accounting (and calendar) years 1967, 1968, and 1969. Accordingly, it is *held* that termination of the agreement between the V Nursing Home and the Department of Health, Education, and Welfare, effective May 30, 1970, was proper and in accord with section 1866 of the Social Security Act and regulations thereunder.

(X—refer to SSR–72–40)

SECTIONS 205(1) and 1866.—NOTICE OF TERMINATION OF PROVIDER-AGREEMENT—DELEGATION OF SECRETARY'S AUTHORITY—RIGHT TO HEARING

20 CFR 405.1020 ff. HCFAR–78–22

Held, the X Hospital was properly notified by the Social Security Administration that its section 1866 participation agreement with the Secretary of

Health, Education and Welfare, would be terminated within 2 weeks, for failure to meet the requirements of that section, since the Administration was acting under a lawful delegation of authority from the Secretary conferred pursuant to section 205(1) of the Social Security Act. *Further held*, the X Hospital was timely advised of its right to bring the matter before a hearings officer of the Administration after the termination action, since, under section 1866 of the act, its right to a hearing flowed *from* the adverse finding, and did not accrue prior thereto.

The X Hospital, participating as a provider of services under section 1866 of the Social Security Act, was advised by the Social Security Administration on February 1 that its participating agreement with the Secretary of Health, Education, and Welfare was being terminated effective February 15, because it no longer met the requirements of that section. This action was taken after a survey of the hospital's facilities, personnel, and operations pursuant to authority granted the Secretary by section 1866(b), which provides in pertinent part as follows:

> An agreement with the Secretary under this section may be terminated—
> (2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but *only after* the Secretary has determined
> (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861 . . . (Emphasis supplied.)

Simultaneously with notice of its termination as a provider of services under title XVIII, the X Hospital was advised of its right to bring the matter before a hearings officer. The hospital has requested a hearing, protesting the termination action on several grounds going to the merits of the termination, which are not here in issue.[1] In addition, the hospital questions the propriety of the terminating action, on the following grounds: (1) that it was entitled to a hearing *prior to* being terminated; and (2) that the Secretary's authority to terminate the provider's agreement had been illegally delegated to the Social Security Administration.

With regard to the contention of the X Hospital that it was entitled to a hearing *prior to* termination as a provider of services under the Act, there is no basis either in the law or regulations of the Administration for such

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[1] The X Hospital had been found not in substantial compliance with the following conditions of participation set out in sections 405.1020 ff. of Regulations No. 5 of the Social Security Administration (20 CFR 405.1020 ff.): (1) that the hospital have an effective governing body; (2) that the physical environment be safe and appropriate to the needs of the patients; (3) that there be a pharmacy or drug room administered in accordance with accepted professional principles; (4) that the medical staff be responsible to the governing body for the quality of medical care furnished patients; (5) that if the hospital has such complementary departments as surgery, anesthesiology, dental or rehabilitation, effective policies and procedures exist to assure the health and safety of patients; and (6) that the hospital have in effect an acceptable utilization review plan. It was also found not in compliance with its section 1866 provider agreement as it relates to charges based on reasonable costs and medically required services. (See SSR 69–11, C.B. 1969, p. 126) for an evaluation of several conditions of participation.

right. Section 1866(b)(2) quoted above, as well as section 205(b) of the Act, provide that the right to a hearing flows from an adverse determination. In this case the determination that the hospital's agreement would be terminated by a certain date, gave rise to the hospital's right to request a review of that determination by a hearing of all the facts and issues involved.

The final point raised by the X Hospital is that its termination by the Social Security Administration as a provider of services was illegal, since, in its view, the Secretary's responsibility for terminating provider agreements under title XVIII of the Act may not be delegated. The case of *Cudahy Packing Company* v. *Holland*, 315 U.S. 355 is cited as its authority therefor. As applicable, the Cudahy case stands for the view that the Secretary cannot delegate his power to subordinates unless the Congress specifically authorizes him to do so. Examination of the Social Security Act discloses that Congress conferred upon the Secretary the power to delegate his authority for the purposes here in question. In enacting Medicare legislation, the Congress provided in section 1872 of the Act, dealing with the application of certain provisions of title II to title XVIII matters, that section 205(1) of the Act would be so applicable. Reference to section 205(1) shows that the Secretary is expressly authorized to delegate to any member, officer or employee of the Department of Health, Education, and Welfare any of the powers conferred upon him by the Act. Pursuant to that authority, the Secretary has conferred upon the Commissioner of Social Security all of his functions under title XVIII. Those functions now are delegated to the Administrator, Health Care Financing Administration. It follows therefore that the X Hospital's argument that its agreement was illegally terminated is without merit.

(X—refer to SSR–72–64)

SECTIONS 1862(a)(9) and 1861(i) (42 U.S.C. 1395(y) and 1395(x)(i)).—HOSPITAL INSRANCE BENEFITS—SKILLED NURSING FACILITY—FAILURE TO PROVIDE EXTENDED CARE SERVICES WITHIN 14-DAY TRANSFER PERIOD

20 CFR 405.120 HCFAR–78–23c

Garoni v. *Richardson*, Civil Action No. 1515–71, U.S.D.C., D. N.J. (6/20/72)

> Where hospital insurance beneficiary, following a qualifying 3-day hospital stay, entered a participating skilled nursing facility within 14 calendar days of discharge from hospital, but neither required nor received covered extended care services within such 14-day period, *held*, beneficiary not entitled to have benefits paid on her behalf for the stay in skilled nursing facility even though beneficiary later did receive skilled nursing care before being discharged from the facility; timely admittance must be coupled with level of care prescribed by statute and regulations, for beneficiary entitlement to payment for services provided to her.

FISHER, District Judge: Plaintiff Chadwick Garoni, executor for the estate of the deceased Mrs. Amelia Garoni, seeks judicial review of a

final decision by the Secretary of Health, Education and Welfare, in accordance with 42 U.S.C. 405(g). The challenged decision denied payment of benefits to the Jersey Shore Medical Center, Neptune, New Jersey, under Part A of the Social Security Act [1] for alleged extended care provided Mrs. Garoni from December 22, 1969 and thereafter. Accordingly, I have examined the record, findings and conclusions of the Hearing Examiner.

Mrs. Amelia Garoni was hospitalized on December 10, 1969, being taken by ambulance from her home to the Jersey Shore Medical Center. Her illness was diagnosed as carcinoma of the ovary with metastasia. Twelve days later Mrs. Garoni was transferred from the hospital unit into the Booker Pavilion, the extended care facility of the Jersey Shore Medical Center. Plaintiff seeks extended care benefits for her stay in this facility under 42 U.S.C. 1395(d).[2] Mrs. Garoni remained at the Booker Pavilion for over 100 days but the claim is only for payment for 100 days, as provided by the statute. This claim was rejected by the Secretary of Health, Education and Welfare in adopting the recommendation of the Social Security Administration's Hearing Examiner.

The basis for the disallowance of plaintiff's claim was because of the Secretary's interpretation of Section 1861(i) of the Social Security Act, 42 U.S.C. 1395(x)(i). This section allows payment for extended care treatment if it is rendered within fourteen days of a qualifying hospital stay. Both sides here agree that Mrs. Garoni's stay in the Jersey Shore Medical Center's hospital facility was such a qualifying stay. There is disagreement, however, as to when she began receiving skilled, rather than merely custodial, care in the extended care facility. If the Secretary's interpretation is corrrect, Mrs. Garoni did not receive the covered care within fourteen days of her discharge from the hospital. Plaintiff takes the position that the statutory provision means only that a patient has to be admitted to an extended care facility within fourteen days from a qualifying hospital stay to recover benefits, with no requirement as to when skilled services begin.

This Court is in agreement with the Secretary's interpretation of the fourteen day provision. Reading the provision in this manner serves to create a direct nexus between the hospital stay and the extended care treatment.

Once this judgment is made, it becomes necessary to determine whether Mrs. Garoni received the type of care that would be covered [3] within the initial post-discharge two weeks. The Secretary has found that she did not. In situations involving judicial review of this type of administrative decision, the Court's role is clear.

This Court's decision to review the challenged decision is limited to the determination of whether that decision is supported by substantial evidence. 42 U.S.C. 405(g) states, "The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . .". To go further would be to overstep well established judicial guidelines" . . . where there is substantial evidence to support the Secretary's determination, the trial

[1] Reference is to Part A of Medicare, Title XVIII of Social Security Act. [Ed.]
[2] Reference is to section 1812 of Title XVIII of the Social Security Act. [Ed.]
[3] Such care refers to skilled nursing services that would qualify an individual for payment of extended care facility benefits. [Ed.]

court has no power to overrule that determination". *Celebrezze* v. *Zimmerman*, 339 F. 2d 496 (5th Cir. 1964) at 497; and similarly *Walker* v. *Altmeyer*, 137 F. 2d 531 (2nd Cir. 1943); *United States* and *Social Security Board* v. *LaLone*, 152 F. 2d 43 (9th Cir. 1945); and *Livingstone* v. *Folsom*, 234 F. 2d 75 (3rd Cir. 1956).

On the record before the Court I must conclude that the decision of the Secretary was supported by substantial evidence. A careful and thorough review of the record has convinced the court that the Hearing Examiner was acting in accord with the weight of the evidence when he disallowed plaintiff's claim.

When Mrs. Garoni was admitted to the extended care facility, she was independently ambulatory, alert, with hearing and sight normal, able to feed herself and communicate. She exhibited good cooperation with the staff and was on a regular diet. She received no intravenous fluids or any sort of therapy. All medication was oral and self administered. The patient did exhibit some dizziness and did require some assistance in bathing.

Section 1861 of the Social Security Act provides for coverage for extended care treatment for "skilled nursing care and related services for patients who require medical or nursing care . . .". Section 1862 of the Social Security Act states at (a) that "no payment may be made . . . for any expenses incurred for items or services . . . (9) where such expenses are for custodial care . . .". What services Mrs. Garoni received during the crucial fourteen day post-discharge period, were only custodial in nature and, thus, not the type of service covered by the Act. These services were not the sort which involved the rendering of skilled nursing care or medical expertise.

Plaintiff has raised questions as to whether Mrs. Garoni did in fact receive that skilled type of treatment during her first fourteen days in the extended care facility. This Court, as noted earlier, is bound to accept the findings of the Secretary as to facts, so long as these findings are supported by substantial evidence. Here his findings are supported in the proofs and the Court will not disturb them.

(X—refer to SSR–73–34c)

SECTIONS 1861(j) and 1866(b)(2)(A), (B) and (C) (42 U.S.C. 1395ff).—PROVIDER PARTICIPATION AGREEMENT—FAILURE TO MAINTAIN PERFORMANCE STANDARDS—FAILURE TO SUBMIT COST REPORTS—TERMINATION OF CERTIFICATION

HCFAR–78–24a

20 CFR 405.614(a)(1), (2) and (3), 405.1120(b), 405.1124, 405.1125, 405.1134–405.1136

Where a provider, certified for participation as an extended care facility under title XVIII of Social Security Act, failed to correct certain deficiencies pertaining to records, personnel, licensing, supervision, food service, physical

environment, and cost accounting reports after repeated inspections, *held*, termination of certification proper for non-compliance with conditions of participation, as required by Act and regulations. *Further held*, Secretary also authorized under statute and regulations to terminate provider participation solely on basis of failure to submit timely cost accounting reports.

The X Nursing Home filed a request to establish eligibility as an extended care facility under title XVIII of the Social Security Act. The application received favorable consideration and the facility was notified that it met the requirements to participate, the agreement becoming effective February 28. 1967.

Subsequently, certain deficiencies were noted pertaining to clinical records and transfer agreements. In October 1967 the facility was notified that evidence indicated it no longer qualified as a provider of services under the Medicare program. The following deficiencies were noted: two nurses on the staff were not currently licensed by the State; there was neither a Registered Nurse nor a Licensed Vocational Nurse who was a graduate of a State-approved school of practical nursing on duty and in charge of the nursing services at all times; and there were an insufficient number of nurses employed to meet the total needs of the patients.

In June 1969 the facility was notified of the determination that it no longer met the requirements for participation and that its agreement with the Secretary, Department of Health, Education, and Welfare was to terminate on July 16, 1969. Following a resurvey on July 11, 1969, the facility was advised on August 7 that serious deficiencies continued to exist and the termination was made effective as of August 11, 1969. Following an unsuccessful hearing before an administrative law judge, the X Nursing Home appealed for a further administrative review.

The general issue is whether the action terminating certification of the facility to participate as a provider of services under the Social Security program was proper.

The specific issues are whether a 24-hour nursing service as required by the Act and regulations was provided (Section 1861(j)(6), and 20 CFR 405.1124); whether such other conditions were met relating to the health and safety of the patients or relating to the physical facilities as required by section 1861(j)(10) of the Act, particularly the Conditions of Participation required by sections 405.1120(b); 405.1125(a), (d), (h) and (i); 405.1134(b) and (i); 405.1135(a) and (c); and 405.1136(b) of Regulations No. 5 of the Social Security Administration; and whether there was a failure to provide such information as is required to determine whether payments are or were due under title XVIII and the amounts thereof, or a refusal by X Nursing Home to permit such examination of its fiscal and other records as necessary to verify such information, as required by section 1866(b)(2)(C) of the Act.

Upon review, the following specific findings of the administrative law judge were affirmed: inadequate 24-hour nursing services; non-compliance as to licensing of staff, nursing supervision, adequacy of nursing personnel, adequacy in quality of nursing care and in-service training; non-compliance with regulations relating to dietary department and physical environment to insure safety of patients; poor housekeeping and maintenance services; lack of a disaster plan; and failure to submit cost accounting or other re-

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ports until after termination of participation. This latter finding is worthy of further comment.

Section 1866 of the Act provides, in pertinent part:

> (b) An agreement with the Secretary under the section may be terminated—
> (2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in Regulations, but only after the Secretary has determined . . . (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Section 405.406 of Regulations No. 5 of the Social Security Administration provides, in part:

> (b) Cost reports will be required from providers on an annual basis with reporting periods based on the provider's accounting year . . . .

Section 405.454 of Regulations No. 5 provided, in part:

> (h) Cost Reporting Period.—For cost reporting purposes the program will require submission of annual reports covering a 12-month period of operations based upon the provider's accounting year . . . .

Section 405.614 of the pertinent Regulations provides, in part:

> (a) Cause for Termination.—The Secretary may terminate an agreement if the Secretary determines that the provider of services:
> (1) Is not complying substantially with the provisions of title XVIII and this Part 405, or with the provisions of the agreement entered into pursuant to 405.606

The agreement between the Secretary and the facility reads, in part:

> The agreement may be terminated by either party in accordance with the provisions of section 1866(b)(1) and (2) of the Social Security Act and regulations thereunder . . . .

The record in this case reveals that no cost reports were filed until after the agreement had been terminated. It appears from the reports finally submitted that the accounting year was a calendar year. Despite numerous requests for submission of the cost reports due for the years 1967 and 1968, none were submitted until on or about September 17, 1969.

It is noted that various administrative steps, short of termination, were taken by the intermediary on behalf of the Secretary because of X's failure to file the required cost reports. Initially, its interim rate of payment was reduced and certain other payments were suspended. A further reduction was made effective February 1, 1969. Finally, payments were held in escrow pending receipt of the required reports. Although administrative penalties may be imposed because of a provider's failure to submit the required reports, the statute and the regulations clearly provide that an agreement may be terminated by the Secretary solely upon the provider's failure to submit cost reports.

Accordingly, since the X Nursing Home was not in substantial compliance with the provisions of its agreement, and with the provisions of the law and regulations, and did not submit such information as necessary to

determine whether payments were due, the Appeals Council *held* that termination of the agreement as a provider of extended care services was proper. **(X—refer to SSR–73–35a)**

SECTIONS 1814, 1861(e) and 1862(a) (42 U.S.C. 1395f, x and y.).—HOSPITAL INSURANCE BENEFITS—MEDICAL NECESSITY FOR INPATIENT SERVICES—CUSTODIAL CARE

20 CFR 405.116(a), 405.310(g), 405.310(k) HCFAR–78–25a

A hospital insurance beneficiary, admitted as a hospital inpatient for treatment of a stroke, remained an inpatient from August 10 through November 13, 1970. Upon admission, she had complete paralysis of right arm and leg, as well as difficulty in speaking. Evaluation was made by attending physician and a team of rehabilitation specialists. A program of treatment was established and monitored by attending physician, which included daily intensive physical, occupational and speech therapy, oral medications, and daily monitoring of blood pressure. Prescribed rehabilitation services were received by patient, who progressed to ambulating with assistance, was able to communicate verbally, and attained good degree of self-sufficiency. *Held*, patient had by October 13, 1970, received maximum benefit in hospital and no longer required a hospital level of rehabilitation care; therefore, payment may be made only for services provided from August 10, 1970 through October 13, 1970.

W, an 80-year old female beneficiary, suffered a stroke and was admitted to X Hospital on August 10, 1970. She was discharged from this facility on November 13, 1970. Hospital insurance benefits under Part A of title XVIII of the Social Security Act were determined payable for the period August 10, 1970 through September 8, 1970, but not thereafter on the basis that a hospital level of rehabilitation care was not required or furnished.

In requesting a review of this determination, the claimant contended that the primary purpose of the hospital stay was to receive physical, occupational, and speech therapy and that according to the "Medicare Handbook" such services are covered when furnished by a qualified hospital.

Section 1814 of the Act provides in part:

(a) Except as provided in subsection (d), payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

* * * * * *

(3) with respect to inpatient hospital services . . . which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose . . .

Section 1861 of the Act provides in pertinent part:

(e) the term "hospital" . . . means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical

diagnosis, treatment and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

Section 1862 of the Act provides, in part:

(a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

* * * * * *

(9) Where such expenses are for custodial care;

The issue to be decided is whether payment may be made on W's behalf for the services provided by the X Hospital for the period from August 10, 1970 through November 13, 1970. Whether such payment can be made depends on whether it was medically necessary for her to receive treatment or rehabilitation services as an inpatient in a hospital.

W's admission record to X Hospital shows that she had paralysis of the right arm and leg. However, she was alert, cooperative, and had control of her bladder and bowels. The aphasia manifested itself in difficulty with word finding as well as uttering wrong words and phrases. There was a slight right facial droop. The right arm and leg had no muscle function and she was unable to stand.

After many consultations between the attending physicians and rehabilitation service doctors at the hospital, it was decided that in order for the claimant to attain the maximum amount of improvement, it would be necessary for her to have a rather prolonged period of hospitalization. She received a rehabilitation program that included physical, speech, and occupational therapy. Physical therapy included a program of active and passive exercises to the right upper and lower extremities with muscle re-education techniques. There were strengthening exercises for the left upper and lower extremities and a mat program for sitting balance, and bed activity. She was to progress to standing and ambulation in the parallel bars when she was able. Speech therapy concentrated on helping her in word finding and encouraging her to read as much as possible. Occupational therapy included a functional program for the right upper extremity to maintain range of motion and stimulate muscle function, sling suspension for the right arm to the wheelchair, and an evaluation of the claimant's progress in her activities of daily life.

The physician's orders on admission to the hospital called for laboratory tests, an electrocardiogram, a physical therapy evaluation, a general diet as tolerated, a sedative, and a pain reliever for headache. The claimant was to be up in a chair with her arm in a sling. Blood pressure was to be checked on a daily basis.

The physician's progress notes indicate that the claimant was considered a good candidate for rehabilitation. Full physical, occupational, and speech therapy programs were ordered on August 11, 1970. Speech improved

significantly by August 18, but no change was noted in physical therapy, with sitting balance poor. The physician noted that he would give the claimant one more week of therapy and if there were still no progress, he would make plans for discharge. On August 27, she was showing improvement and was now walking in the parallel bars. Her mood was good and her attitude toward the therapy programs was very optimistic. On September 1, strength gains were noted in the right hip. On September 8, the improvement in speech was marked. She was speaking clear words and making good sentences. On September 16, there was further encouraging improvement in physical therapy. On September 24, there was a leveling off in physical therapy improvement and small gains in occupational therapy. Discharge was again considered by the physician. However, by September 29, the claimant again made gains by ambulating in the parallel bars. On October 3, there was improvement in movement of her arm and leg. Further improvements were noted on October 5 and October 10. On October 13, she was noted to be stabilizing in her therapies. At that time, discharge was discussed with her husband. On October 17, she had no complaints and on October 21, her status remained the same. On November 3, there was further slow improvement in ambulation.

The nurse's notes reiterate the progress record, as did reports by each of the rehabilitation therapists in his particular specialty. A hospital resident physician expressed his belief that slow but definite gains were made over the entire hospitalization period, and that as long as she continued to make improvement further hospitalization was warranted. An attending physician stated that W could not have received the intensive care necessary for recovery of her speech and paralysis had it not been for prolonged hospitalization. A member of the hospital utilization review committee believed that while W achieved plateaus several times during her stay, as long as she improved at a reasonably steady pace with home placement as an objective, her care could not be classified as custodial. However, a medical advisor, responding to an interrogatory, indicated his belief that hospitalization was primarily for convenience sake. He noted that all medications could have been self-administered and controlled at home.

In the present case, the primary reason for W's hospitalization was for rehabilitation therapy. In the opinion of the Appeals Council a patient would be deemed to require a hospital level of care if he required a relatively intense rehabilitation program which required a multidisciplinary coordinated team approach to upgrade his ability to function as independently as possible. A program such as this would usually include intense skilled rehabilitation nursing care, physical therapy, occupational therapy and speech therapy, if needed. The attending physician and the therapy specialists would consult often and note progress. An assessment would be made of the patient's medical condition, functional limitations, prognosis, attitude toward rehabilitation and existence of social problems. Reasonable

goals would then be made and revised if necessary.

The Council believes that the claimant received a sufficiently intense program of rehabilitation to require hospitalization. She received physical, occupational, and speech therapy 4 to 5 hours daily. These treatments were ordered by the attending physician in consultation with qualified therapists and were overseen by him. There were periodic progress checks to determine if the therapy was of sufficient benefit to the claimant to warrant continued hospitalization. Several times discharge was discussed when progress was minimal. However, the claimant would then make significant progress and a further stay was granted.

The goal of independent ambulation was not considered realistic. Instead, the goal of walking with aid and being able to communicate and achieve a good degree of self-sufficiency was substituted. It is clear from the record that the claimant benefited greatly by the rehabilitation therapy. However, it is also shown from the record that the claimant's improvement had reached a plateau by October 13, 1970. At that time, it was believed by the hospital staff that goals had been achieved and that any further treatment could have been accomplished at home. The attending physician consulted with the claimant's husband, and the main problem after October 13, 1970, appeared to be one of obtaining a housekeeper. Nonetheless, the claimant was kept in the hospital for another month with no significant improvement.

Accordingly, the Appeals Council *held* that claimant had, by October 13, 1970, received maximum benefit in the hospital and no longer required a hospital level of rehabilitation care; therefore, payment may be made for services provided W from August 10, 1970 through October 13, 1970, but not thereafter.

(X—refer to SSR–73–49a)

SECTIONS 1812(a), 1814(a), 1861(j), and 1862(a)(9) (42 U.S.C. 1395ff.).—POST-HOSPITAL EXTENDED CARE SERVICES—SKILLED NURSING FACILITY—CUSTODIAL CARE EXCLUSION

20 CFR 405.120 and 405.126–405.128 HCFAR–78–26c

Maurice C. Johnson v. *Richardson*, 336 F.Supp. 390 (E.D. Pa., 1971)

Where hospital insurance beneficiary received payment for post-hospital services provided by a skilled nursing facility from May 19, 1969 through May 31, 1969, but was denied benefits thereafter through July 7, 1969, on basis that the continuing availability of skilled nursing care was no longer required, *held*, final decision of the Secretary supported by substantial evidence since at no time during questioned period did claimant require or receive skilled nursing care on a continuing basis for any condition for which hospitalized;* inability of spouse to assist in his care is not an eligibility factor; nor is fact that claimant may "do better" in such facility a test under the statute.

*For level of care requirements effective January 1, 1973, see section 1814(a)(2)(C) of Act as changed by section 247 of Social Security Amendments of 1972 (Public Law 92–603). For limitation on liability of a beneficiary where his Medicare claim is disallowed, see section 1879 of Act as added by section 213 of P.L. 92–603, effective November 1, 1972.

TROUTMAN, J.

This action, brought against the Secretary of Health, Education and Welfare, pursuant to Section 1869 (b) of the Social Security Act, 42 U.S.C. § 1395 (f) (d),** seeks to review a final decision of the Secretary, denying the plaintiff the payment of benefits for services provided to him, Maurice C. Johnson, as an in-patient at the Haverford Nursing Center, during a portion of the period May 19, 1969, through July 7, 1969.

Judicial review is governed by the provisions of Section 205(g), 42 U.S.C. § 405(g), which provides, inter alia, "the findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive * * *". This Court has no authority to hear the case de novo. *Thomas* v. *Celebrezze*, 331 F.2d 541 (4th Cir. 1964); *Mauldin* v. *Celebrezze*, 260 F. Supp. 287 (D.C.S.C. 1966).

Therefore, the question here involved is whether there is substantial evidence to support the Secretary's decision. To answer this question, it is the duty of this Court to look at the record as a whole. *Boyd* v. *Folsom*, 257 F.2d 778 (3rd Cir. 1958); *Klimaszewski* v. *Flemming*, 176 F. Supp. 927 (E.D. Pa. 1959).

"Substantial evidence" has been defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion". *Consolo* v. *Federal Maritime Commission*, 383 U.S. 607, 620. 86 S. Ct. 1018, 1026, 16 L. Ed. 2d 131 (1966); *Consolidated Edison Co.* v. *Labor Board*, 305 U.S. 197, 229 (1938). It "must do more than create a suspicion of the fact to be established", *NLRB* v. *Columbian Enameling and Stamping Co.*, 306 U.S. 292, 300. It must be enough, if the trial were to a jury, to justify a refusal to direct a verdict when the conclusions sought to be drawn from it is one of fact for the jury. If there is only a slight preponderance of the evidence on one side or the other, the Secretary's findings should be affirmed. *Underwood* v. *Ribicoff*, 298 F.2d 850, 851 (4th Cir. 1962).

Section 1862 of the Act, 42 U.S.C. § 1395(y), lists a number of "exclusions from coverage". Among others, there is Section 1862(a) (9), 42 U.S.C. § 1395(y)(a)(9), which provides for an exclusion "where such expenses are for custodial care". Basing its decision upon such exclusion, the Appeals Council concluded, inter alia, as follows:

> In summary, the medical evidence of record indicates that the claimant was ill while at the Haverford General Hospital and that a period of restorative care might have been necessary immediately after discharge from the hospital. However, it does not show that at any time during the period at issue, that is, from June 1 to July 7, 1969, the claimant needed and received skilled nursing care on a continuing basis for any condition or conditions with respect to which he was receiving inpatient hospital services prior to entering the

**Reference should be: 42 U.S.C. 1395ff(b). [Ed.]

Haverford Nursing Center or for a condition which arose while receiving extended care for treatment of the original condition.

Therefore, it is the decision of the Appeals Council that the claimant is entitled to have payment made on his behalf for post hospital extended care services received in the Haverford Nursing Center for the period from May 19, 1969 to June 1, 1969, but not for the period June 1 to July 7, 1969. The decision of the hearing examiner is reversed.

Thus, we are here concerned with the question whether the findings and conclusion of the Appeals Council is supported by "substantial evidence" as that term has been defined by the Courts.

Turning now to the record, we note that the hearing examiner found otherwise, having concluded, on April 30, 1970, that the plaintiff, during the period in question, "required skilled nursing services" and was, therefore, entitled to coverage under the Act. This decision followed a hearing held before the examiner on April 10, 1970, at which time Mrs. Evelyn Miller, a registered nurse, testified that, based upon her nursing experience and as a friend of Mrs. Johnson, she was of the opinion that Mrs. Johnson could not have taken care of the patient and plaintiff, Mr. Johnson, during the period June 1969. She spoke as a friend of the family, basing her conclusions upon observations made during social visits. She has never rendered any professional services to the plaintiffs. She did visit Mr. Johnson while he was in the nursing home, but did not, during her visits, observe that he received any medication. He was in bed and, according to her, "receiving no particular care", just "lying in bed talking with us".

Dr. Norman Learner reviewed the record and concluded that during the period in question, Mr. Johnson "needed primarily custodial care". He conceded that while the plaintiff might "do better" in an extended care facility, he was of the opinion that the care rendered to the plaintiff during the period in question was "custodial as contrasted with medical". He made those determinations based upon the records and without examination of the plaintiff at the time. After looking at the record, he concluded that the type of care which the plaintiff was receiving was "custodial" in nature. He buttressed his conclusion with observations that the plaintiff was receiving oral medications only which "could have been administered by a non-professional or non-skilled personnel". He also pointed out that during the period in question the attending nurses made only four entries on the plaintiff's record, namely, on May 19 the plaintiff's admission was noted: on May 20 he was visited by the doctor; a third note that he received some aspirin and, finally, a fourth entry on July 6 that he was being discharged. It was the conclusion of the witness that the lack of entries and lack of notes on the plaintiff's record indicated lack of professional treatment which, combined with other evidence on the records, led the witness to the professional conclusion that the plaintiff "primarily received custodial care". He failed to find "any evidence that he (plaintiff) required any expert care". He conceded that on one occasion an electro-

cardiogram was done. that from time to time the blood pressure and pulse were taken, the latter done every day and likewise noted specifically the medications being given the plaintiff. For the conditions from which the plaintiff suffered he said observation by a physician was required only "every three or four weeks". Careful cross-examination of the witness established that Mrs. Johnson, in her condition, might not have been able to take care of the plaintiff, Mr. Johnson. However, the ability or inability of his spouse to assist in the care of a patient is not determinative of eligibility under the Act.

Turning to the balance of the record which does not consist of oral testimony, but rather of entries placed upon the plaintiff's chart during his stay at the nursing home and during the period in question, we note that the "doctor's progress notes" show that following admission on May 19, 1969, plaintiff's condition was noted, on May 23, as "greatly improved from time of admission to Haverford Hospital". On May 31 it was noted "abnormal fibrillating gone except for occasional episodes of fibrillation". On June 3 it was noted "mind clearer-pulse regular". On June 12, 1969, it was noted 'patient doing well, pulse regular and almost nsr (normal sinus rythmn). On July 1 it was noted "condition unchanged".

These original entries made at the time by the attending physician clearly support the Secretary's decision here reviewed.

Similarly, the "doctor's orders", only three in number, entered on May 19, May 23 and July 3, 1969, likewise support the Secretary's decision. The subject-matter of the entries made and the services ordered do not support the conclusion that trained and professional personnel were required to administer effectively to the plaintiff's medical needs.

The entries made by the nurses on the "nurses record" during the period in question do not support the plaintiff's contention. Such entries are only four in number, the first being on May 19, relating to the plaintiff's admission, and noting that he was "able to walk around". The next entry was made on May 20, at which time it was suggested that the plaintiff "had (a) good day". The next entry was on June 26, at which time bufferin was administered "for headache" and, finally, on July 6 it was noted that the patient was discharged to his home in care of his family.

We have likewise noted the reports of Dr. Edward H. Kotin. We have otherwise reviewed the record in its entirety including certain other notations and entries made by Dr. Kotin. Thus, we have considered the record as a whole and in its entirety. It seems evident that there is substantial evidence to support the conclusion that by June 1, 1969, the plaintiff's recovery had progressed to the point where skilled nursing services on a continuing basis were no longer required. That the plaintiff might be more comfortable or even "do better" in an extended care facility is not the test under the statute. Neither may be considered the understandable fact that his wife, likewise elderly and deaf, was not capable of looking after his needs at home. The

plight of senility, and the burdens that the physical debilities indigenous to old age can place not only on the aged sufferers themselves, but also on their families who care for them, are not to be disputed. Resulting and understandable sympathies for the plight of these fine old people cannot be the basis for our decision. It is to the Social Security Act and to its provisions that we must look, as did the Secretary and the Appeals Council, in reaching a conclusion. We may not weigh or re-weigh the evidence. *Celebrezze* v. *Zimmerman*, 339 F.2d 496, (5th Cir. 1964).

The burden of proof is upon the one seeking the benefit of the statute. *Staples* v. *Gardner*, 357 F.2d, (5th Cir. 1966). The credibility to be given to the testimony of the various witnesses and the weight to be given to the evidence are matters to be determined by the Secretary. *Stillwell* v. *Cohen*, 411 F.2d 574 (5th Cir. 1969); *Celebrezze* v. *Zimmerman, supra.* Similarly, conflicts in the evidence and the reasonable inferences to be drawn therefrom are matters to be resolved by the Secretary. *Martin* v. *Finch*, 415 F.2d 793 (5th Cir. 1969).

Viewing the record as a whole, it contains substantial evidence to support the Secretary's conclusions. On the entire record, we conclude that the denial of benefits was proper. In reaching such conclusion we have carefully considered the admonitions of the Court in *Universal Camera Corporation* v. *National Labor Relations Board*, 340 U.S. 474 (1951) and have accorded to the findings of the examiner the relevance which we believe they reasonably command in determining the answer to the comprehensive question whether the evidence supporting the Secretary's order is substantial. We have, as indicated, considered the record as a whole including the findings and conclusions of the examiner.

The plaintiff's motion for summary judgment will be denied and the Secretary's motion for summary judgment will be granted.

(X—refer to SSR–73–51c)

SECTIONS 205(a) and 1861(i) * (42 U.S.C. 405(a) and 1395x(i)).—HOSPITAL INSURANCE BENEFITS—3—CONSECUTIVE—DAY HOSPITAL STAY REQUIREMENT PRIOR TO ADMISSION TO SKILLED NURSING FACILITY—VALIDITY OF SECRETARY'S REGULATIONS

20 CFR 405.120(c) HCFAR–78–27c

AMOS V. WEINBERGER, U.S.D.C., M. D. Tenn., Civil Action No. 6762, (6/4/73)

A claimant for hospital insurance benefits under Part A of title XVIII of the Social Security Act, was admitted as a hospital in-patient on December 30 and discharged January 1st. Although the claimant was admitted on January 9 to a participating skilled nursing facility, program payment was denied for failure to meet the 3-consecutive-day hospital stay required by section 1861(i) of Act. *Held*, the Secretary's regulation, which provides that for purposes of the 3-consecutive day requirement the calendar day of admission is counted but not the calendar day of discharge, is not unreasonable given the statutory requirement and is not in excess of the authority delegated the Secretary; *further held*, as applied to this case the regulation precludes Medicare reimbursement for services furnished in the skilled nursing facility.

SMITH, District Judge:

This is an action brought to review a final decision of the Secretary of Health, Education and Welfare pursuant to provisions of § 205(g) of the Social Security Act, as amended. 42 U.S.C. § 405(g).

Lonnie F. Neal, who was entitled to hospital insurance benefits under Part A of Title XVIII of the Social Security Act, was admitted as an in-patient to the Vanderbilt University Hospital, Nashville, Tennessee, on December 30, 1970, and discharged on January 1, 1971. On January 9, 1971, he was admitted to the MediCenter of Nashville in Nashville, Tennessee, a participating extended care facility. Program payment to the MediCenter of Nashville on behalf of Mr. Neal for services he received there was denied because he had not met the three-consecutive-day hospital stay requirements as set forth in 42 US.C. § 11395x(i) prior to his admission to

*Section 1861 (i) provides: The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 14 days after such discharge from such hospital, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C) within such time as it would be medically appropriate to begin an active course of treatment in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital; an individual shall be deemed not to have been discharged from a skilled nursing facility within 14 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility. (Ed.)

the extended care facility. *This suit is brought by Mrs. Evelyn Amos on behalf of her father. Lonnie F. Neal. now deceased.

It is admitted that to obtain post-hospital extended care services, the deceased must have received in-patient care from a hospital for not less than three consecutive days before his discharge from the hospital in connection with his transfer to a facility for post-hospital extended care services.

Title 42 U.S.C. § 1395x(y)(4) provides:

> (4) For purposes of subsection (i) of this section, the determination of whether services furnished . . . constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

Title 42 U.S.C. § 405(a) provides:

> (a) The Secretary shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.**

The reason for having a three-day requirement is found in the following excerpt from the Act's legislative history:

> "The 3-consecutive-day hospital inpatient requirement is a period of 3 consecutive calendar days beginning with the calendar day of admission even if less than a 24-hour day, and ending with the day before the calendar day of discharge. Thus, in determining whether the 3-consecutive-day requirement is met, the day of admission is counted as one day; the day of discharge is not counted as a day; and each intervening day is counted as a single day." 20 C.F.R. § 405.120(c).***

In meeting the three-day requirement, plaintiff asserts that since the deceased entered the hospital on December 30, 1970, and left on January 1, 1971, he had been hospitalized for three calendar days. It is contended that rules and regulations which more narrowly construe such a period should be judicially disregarded as unreasonable and illegal. However, the construction sought by plaintiff could lead to a period of hospitalization far shorter than that envisioned by the lawmakers. For instance, if a patient

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*The 1972 Amendments to the Social Security Act provided that wherever the term "extended care facility" appeared in title XVIII, the term "skilled nursing facility" should be substituted. (Ed.)

**This provision applies with respect to Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.. to the same extent as it is applicable to Title II. See Section 1872 of the Act, 42 U.S.C. 1395ii. Also see Section 1871, 42 U.S.C. 1395hh. (Ed.)

***The Court refers to the excerpt as legislative history, but the excerpt cited is the text of the regulation, 20 C.F.R. § 405.120(c). (Ed.)

entered the hospital at 11:59 p.m. on December 30, 1970, and left at 12:01 a.m. on January 1, 1971, the period of hospitalization, although spanning three calendar days, would be only two minutes in excess of 24 hours. At the other extreme, admittedly, could occur the situation in which a patient entered at 12:01 a.m. on December 30, 1970, and left at 11:59 p.m. on January 1, 1971. In this instance, the patient would lack only two minutes of being hospitalized 72 hours, and yet would not meet the Secretary's three-consecutive-day requirement, which could have been satisfied in a shorter time spread over an additional calendar day. Notwithstanding, however, the possible disparity of actual inpatient time which could occur under either calculation, the question remains whether, in light of the congressional purpose of achieving adequate medical evaluation, the Secretary's regulation is unreasonable and in excess of the power granted him by the Act. Furthermore, the answer must recognize that the Secretary's regulations must be designed to cover all possible situations, not merely those which occur at the extremes of the three-day time period.

In *Mourning* v. *Family Publications Service, Inc.*, No. 71–829 (U.S. Sup.Ct., decided April 24, 1973), the Supreme Court stated:

> We have consistently held that where reasonable minds may differ as to which of several remedial measures should be chosen, courts should defer to the informed experience and judgment of the agency to whom Congress delegated appropriate authority. [Citing cases.] *Id.* at 15.

Furthermore the court stated that where regulations are reasonably related to the purposes of the enabling legislation, the regulations will be sustained.

It is further stated by the Supreme court:

> We have noted above that the objective sought in delegating rulemaking authority to an agency is to relieve Congress of the impossible burden of drafting a code explicitly covering every conceivable future problem . . . *Id.* at 19.

Based on the rationale of the above-quoted case, this court cannot say that the Secretary, when confronted with the task of setting forth practical rules in applying the "three consecutive days" of required hospital care, exceeded his authority or made an unreasonable practical application.

Therefore, this case is hereby dismissed.

(X—refer to SSAR–74–15c)

SECTIONS 205(g) and 1869(b) (42 U.S.C. 405(g) and 1395ff(b)).—HEALTH INSURANCE BENEFITS—DETERMINATIONS—APPEALS

20 CFR Part 405.730 HCFAR–78–28c

Martha and Lawrence Pankau v. *Weinberger*, U.S.D.C., W.D. of Mo., St. Joseph Div., No. 73–Cv–32–SJ and No. 73–Cv–33–SJ (11/13/73)

> Where hospital insurance beneficiaries were denied payment for expenses for hospitalization amounting to $325.50 and $408.75, respectively, and sought judicial review of the Secretary's decision, *held* under the provisions of section 1869(b) of the Social Security Act, as amended, the court lacks jurisdiction to review final decisions of the Secretary under Part A of title XVIII where the amount in controversy is less than $1,000.

DUNCAN, Senior Judge:

In each of the above entitled cases the plaintiff seeks to have this court review a decision of the defendant Secretary of Health, Education and Welfare, denying hospital benefits under the Medicare program, Part A, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

The Secretary has filed Motion to Dismiss each of the cases on the ground that the court lacks jurisdiction over the subject matter. Since the cases contain common issues of law and fact they will be consolidated for the purposes of this order.

The material facts are established by the affidavits of H. Dale Cook, Chairman of the Appeals Council and Director of the Bureau of Hearings and Appeals, Social Security Administration, Department of Health, Education and Welfare. The plaintiffs have not filed counter-affidavits nor have they filed suggestions in opposition to the Secretary's motions as required by Rule 10(c) of the Local Rules of this court.

Prior to August 1971 both of the plaintiffs were enrolled in Part A of the Medicare program. On August 22, 1971, while they were enrollees under the Act, each of the plaintiffs was admitted to the Missouri Methodist Hospital in St. Joseph, Missouri. They remained in the hospital as patients through August 29, 1971. The expenses for Martha Pankau's hospitalization totaled $325.50, and the expenses for Lawrence Pankau's hospitalization totaled $408.75.

The Secretary denied payment for such amounts for the reason that they were not incurred as a result of necessary hospital care. Payment was denied pursuant to § 1862(a)(1) of the Social Security Act.

On March 9, 1972, following a hearing, the determinations of the Secretary were affirmed by an administration law judge (hearing examiner). The Appeals Council of the Social Security Administration on May 1, 1973, denied a request by each of the plaintiffs for a review of the hearing examiner's decision. The plaintiffs filed these actions on June 27, 1973 seeking a review of the decisions by this court under sections 205(g) and 1869(b) of the Act. 42 U.S.C. §§ 405(g), 1395 ff(b).

In his motions to dismiss the Secretary contends that this court lacks jurisdiction to review such determinations since the amount in controversy in each of the cases is less than $1,000.00.

In October 1972 section 1869(b) of the Social Security Act was amended by Public Law No. 92–603 § 2990. The amendment states in part:

> (a) Section 1869(b) of the Social Security Act is amended to read as follows: (b)(1) any individual dissatisfied with any determination under subsection (a) as to—
>
> * * * * * *
>
> (c) the amount of benefits under Part A (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).
>
> (2) Notwithstanding the provision of subparagraph (c) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (c) if the amount in controversy is less than $100; *nor shall judicial review be available to an individual by reason of such subparagraph (c) if the amount in controversy is less than $1000.* [Emphasis supplied]

Clearly, under the provisions of § 1869(b), as amended, this court does not have jurisdiction to review final decisions of the Secretary under Part A of Title XVIII of the Act, where the amounts in controversy do not exceed $1,000.* Since the expenses which are the subject matter of these sections were incurred in August, 1971 and the amendment to § 1869(b) was enacted on October 30, 1972, it becomes important to determine the effective date of the amendment. In this regard § 2990(b) of Public Law 92–603 provides that:

> "(2) The provisions of paragraph (2) and of subparagraph (c) of paragraph (1) of section 1869(b) of the Social Security Act, as amended by subsection (a) of this section, shall be effective with respect to any claims under part A of title XVIII of such Act, filed—
>
> * * * * * *
>
> (I) before the month in which this Act is enacted [Oct. 1972], but only if a civil action with respect to a final decision of the Secretary of Health, Education, and Welfare on such claim has not been commenced under such section 1869(b) before such month." [Emphasis supplied]

Simply stated, the 1972 amendment of section 1869(b) applies to all claims filed with the Secretary prior to October 1972, if a civil action with respect to those claims has not been commenced prior to that date. Since these actions were brought subsequent to October 1972 the 1972 amendment applies.**

In view of the clear and unequivocal provisions of § 1869(b) as amended, this court is without jurisdiction over the subject matter of the actions. The motions of the Secretary to dismiss are sustained. IT IS SO ORDERED.

(X—refer to SSR–74–22c)

SECTION 1869(b) (42 U.S.C. 1395ff (b)).—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—DETERMINATIONS—APPEALS

20 CFR 405.835 HCFAR–78–29c

Selma Mitchell v. *United Medical Service*, U.S.D.C., S.D. of N.Y., No. 73 Civ. 2196 (11/27/73)

> Where Medicare beneficiary who sought reimbursement for portion of dentist's bills under Part B of title XVIII of the Social Security Act, as amended, was denied such reimbursement and requested judicial review of the Secretary's decision, *held*, while judicial review is provided by statute for claims relating to Part A charges when the amount in controversy is $1,000 or more, there is no provision for judicial review of the amounts payable on claims under Part B.

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*Section 1869(b), as amended, provides that judicial review shall not be available to an individual if the amount in controversy is less than $1,000 rather than $1,000 or less. (Ed.)

**The amendment merely clarifies the original intent of section 1869(b). See H.R. Rep. No. 92–1605, 92d Cong., 2d Sess. 61 (1972). Also see the remarks of Sen. Bennett of Utah upon introducing this amendment. 118 Cong. Rec. S 17049 (daily ed 10/5/72). (Ed.)

GAGLIARDI, District Judge:

This action by Selma Mitchell, pro se, seeks reimbursement for a portion of the $295.00 of dentist's bills under Part B of the Medicare Statute, 42 U.S.C. § 1395, et seq. from the United Medical Service, Inc. (hereinafter UMS), a contracted private "carrier" under 42 U.S.C. § 1395u. The real party in interest in this proceeding, the United States of America, 20 C.F.R. § 405.670, moves to dismiss the complaint on the grounds that (1) a statutory right to judicial review of allowance determinations is not granted by the Medicare statute and (2) the United States of America has not consented to a suit of this nature.

In April, 1970 and again in February, 1971, Dr. Harry Roth performed dental surgery on Mrs. Mitchell in his office. Mrs. Mitchell's application for reimbursement for the initial surgery was granted. However, after a hearing by the hearing officer, reimbursement for the February, 1971 surgery was denied on the ground that the services performed fell within the statutory exclusion from coverage for "structures directly supporting teeth" as provided in 42 U.S.C. § 1395y (a) (12).

While judicial review is provided by statute for claims relating to hospital charges (Part A charges) in excess of $1,000.00[sic] [1] 42 U.S.C. § 1395ff, the statute fails to provide a similar remedy for doctor and other health charges (Part B charges), those at issue before us. Accordingly, plaintiff has no statutory right to judicial review of her claim under the Medicare statute. *See Kuenstler* v. *Occidental Life Insurance Company*, 292 F. Supp. 532 (C.D. Cal. 1968).

Finally, since jurisdiction over plaintiff's claim is excluded by statute and there is no waiver of sovereign immunity by the United States of America, the real party in interest, this Court lacks jurisdiction over the parties to the action. *Blackmar* v. *Guerre*, 342 U.S.512(1952); *Delehite* v. *United States of America* 346 U.S. 15 (1953).

Judgment shall enter against plaintiff Mitchell, and in favor of defendant United Medical Service, Inc. dismissing plaintiff's complaint.

[1] Section 1869 (b) of the Social Security Act, as amended, provides, in pertinent part, for the judicial review of determinations made as to the amount of benefits under Part A if the amount in controversy is $1,000 or more. (Ed.)

(X—refer to SSR–74–23c)

SECTIONS 1866(a)(1)ff (C) 1866(b)(2) and 1902(a)(28), (42) U.S.C. 1395cc(a)(1)ff (C), 1395cc(b)(2), and 1396a(a)(28)— HEALTH INSURANCE—NON-RENEWAL OF PROVIDER AGREEMENT

20 CFR 405.1901–405.1908 HCFAR–78–30c

Olga Nicobatz, et al. v. *Weinberger*, U.S.D.C., Central District of California, No. CV 74–1778–WPG(7/15/74)

Plaintiff-patients following notification that reimbursement for care will end thirty days thereafter if they remain in the plaintiff-facility past the date that the provider agreement expires, contend that they are entitled to an administrative hearing before payment for care can be terminated. The plaintiff-facility contends that due process requires a prior evidentiary hearing before refusal to enter into new provider agreement. The Secretary had noted numerous deficiencies regarding the Conditions of Participation and provided the facility with written notice. These were not corrected and the Secretary refused to enter into a new agreement. A reconsideration was requested and a followup inspection made. The facility was again found out of compliance and the reconsideration affirmed the Secretary's initial determination. *Held*, plantiff-facility has no right to continued participation nor was a prior hearing required on the decision not to renew the agreement. This does not violate due process. The patients are not being denied continued coverage in any facility that meets the conditions of participation.

GRAY, Dist. Judge:

The Court having considered the Motion, the memoranda submitted by the parties and the oral arguments at the time of the hearings, and after due deliberation the Court makes the following Findings of Fact and Conclusions of Law:

FINDING OF FACT

I

Plaintiffs are seven Medi-Cal beneficiaries who are patients at Academy Convalescent Center, Inc., and the Convalescent Center which has been participating since August, 1971 as a provider of skilled nursing home services under Title XVIII (Medicare) and Title XIX (Medi-Cal) of the Social Security Act. Plaintiffs brought this action for a preliminary and permanent injunction to compel the defendants to allow Academy Convalescent Center, Inc. to continue to participate in the Medicare and Medi-Cal Programs beyond the time that the provider agreements with defendants expired (June 30, 1974 for Medicare and July 18, 1974 for Medi-Cal). Plaintiff-patients have been notified that payment for their care will not be made if they remain at Academy Convalescent Center past the date the Medi-Cal agreement expires on July 17, 1974.[1]

II

Plaintiff-patients contend that they are entitled to an administrative hearing before payment for their care at Academy Convalescent Hospital be terminated.

[1] Under section 1866(b)(3), reimbursement under Title XVIII continues for thirty days thereafter if the beneficiary was admitted to the facility prior to the effective date of expiration. (Ed)

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III

Plaintiff Academy Convalescent Center, Inc. contends that due process requires a prior evidentiary hearing before the defendants can refuse to enter into new provider agreements with it. To the extent that the regulations (20 C.F.R. 405.1501, *et seq.*) do not provide for a prior hearing, plaintiff contends that they are violative of due process.

IV

On May 30, 1974, Plaintiff Academy Convalescent Center, Inc. was notified that the Secretary of Health, Education and Welfare would not sign a new provider agreement with it as a skilled nursing facility for participation in the Health Insurance for the Aged and Disabled (Medicare) when the then current agreement expired on June 30, 1974. That decision was based upon inspections on February 19–21, 1974, March 11, 1974 and April 3, 1974 which disclosed numerous continuing violations of the Conditions of Participation of Skilled Nursing Facilities as contained in 20 C.F.R. 405.1120 through 405.1137 and the statutory requirement set forth in 42 U.S.C. 1861(j).[2] The violations documented on February 19–21, 1974 and March 11, 1974 were considered by the Secretary to be so severe as to jeopardize the health and safety of the Medicare patients at Academy and to seriously limit Academy's capacity to render the level of care to Medicare patients required by Section 1861(j) of the Social Security Act and implementing federal regulations at 20 C.F.R. 405.1120 through 405.1137. Some of these violations (deficiencies) were noted during previous on-site inspections on June 13–15, 1973 and July 30–31, 1973 and were brought to the attention of Academy through written notices at those times but were not corrected. Plaintiff Academy was advised of its right to request a reconsideration of such determination.

V

On June 14, 1974 the Department of Health, State of California, notified plaintiff Academy Convalescent that in view of the findings and action of the Secretary of Health, Education and Welfare it would not sign a new provider agreement for the facility to participate in the Medi-Cal program after the current agreement expired July 17, 1974 for the same reasons found and stated by the Secretary in his letter of May 30, 1974. This action by the State agency was taken pursuant to Section 246 and 249A, Public Law 92–603 which amended Sections 1902(a) (28) and 1910(a) of the Social Security Act in 1972 to standardize the conditions of participation under Medicare (Title XVIII) and Medi-Cal (Title XIX) effective January 1, 1974. 45 C.F.R. 249.33 (a)(9).

VI

On June 6, 1974, Academy Convalescent Center, Inc. requested reconsideration of the Secretary's May 30, 1974 determination not to enter

[2] Reference is to section 1816(j) of the Social Security Act, 42 U.S.C. 1395x(j). (Ed)

into a new provider agreement. A follow-up inspection of Academy was conducted at the directions of the Secretary on June 28, 1974. That inspection showed Academy continued to be deficient with respect to a substantial number of provisions of the Medicare conditions of participation that apply to skilled nursing facilities. Accordingly, by letter dated July 3, 1974 the Secretary notified Academy that upon reconsideration [under 20 C.F.R. 405.1514] the initial determination of May 30, 1974 was affirmed. Plaintiff Academy was advised of its right to request a hearing before an Administrative Law Judge [20 C.F.R. 405.1531, *et seq.*] followed by review by the Appeals Council of the Social Security Administration's Bureau of Hearings and Appeals [20 C.F.R. 1561, *et seq.*] and then judicial review as authorized by Section 1869(c) of the Social Security Act (42 U.S.C. 1395ff).

CONCLUSIONS OF LAW

I

Plaintiff Academy had time limited contracts for participation in both the Medicare and Medi-Cal programs. It also knew by the various on-site inspections and consultations that the government agencies were dissatisfied with the level of care given to its Medicare and Medi-Cal patients. Under those circumstances, plaintiff Academy had no expectancy of renewal that would constitute a right under the due process clause of the 5th or 14th Amendments. *Board of Regents* v. *Roth*, 408 U.S. 564 (1972). Plaintiff Academy has no right to continue participating in the Medicare and Medi-Cal programs so as to require a hearing by defendants prior to their deciding not to renew the provider agreements. *Arnett* v. *Kennedy*, 42 L.W. 4513 (April 16, 1974).

II

Even if plaintiff Academy had some type of right to continue to participate in the Medicare and Medi-Cal programs, the welfare of the patients is of primary importance. The defendants have determined that the health and safety of Medicare and Medi-Cal patients at Academy can no longer be assured. On balance of the interests involved here, due process does not require a pretermination type hearing. *Goldberg* v. *Kelly*, 397 U.S. 254 (1970). The post-termination type hearing set forth in 20 C.F.R. 405.1501(b) and 20 C.F.R. 405.1530, *et seq.*, is sufficient procedural due process. *Coral Gables Convalescent Home, Inc.*, v. *Richardson*, 340 F. Supp. 646 (S.D. Fla. 1972).

III

By the numerous inspections and conferences with government officials concerning the deficiencies in the level of care and the repeated opportunities to correct those deficiencies, plaintiff Academy has had considerable due process already. Under the circumstances, it cannot be said that due process also requires a full hearing prior to a refusal to enter into a new provider agreement. *Wilson Clinic & Hospital, Inc.* v. *Blue Cross of South Carolina*, 494 F.2d 50 (4th Cir. 1974).

IV

Medi-Cal benefits to the plaintiff-patients are not being suspended,

terminated or revoked within the holding of *Kelly* v. *Goldberg, supra.* Benefits will continue on behalf of the patients at any nursing facility that has a provider agreement with the California State Department of Health. Due process does not require that the plaintiff-patients be given a hearing prior to the date that the Medi-Cal agreement expires between Academy and the Department of Health.

V

The action of the defendants in not entering into new provider agreements with plaintiff Academy is based, *inter alia,* upon the finding that the care given to the Medicare and Medi-Cal beneficiaries is not at the level required by the pertinent federal statutes and regulations, 42 U.S.C. 1395x(j); 42 U.S.C. 1396a(a) (28); 20 C.F.R. 405.1120–405.1137. Defendants are not shutting down Academy Convalescent Center, Inc., they are merely causing the patients that they are responsible for to be removed to a facility that meets the requirements and conditions for participation under the Medicare and Medi-Cal programs.[3]

VI

Plaintiffs have not been denied due process and their Motion for Preliminary Injunction should, therefore, be denied.

(X—refer to SSR–75–7c)

SECTIONS 205(g), 1862(a)(9), and 1869(b) (42 U.S.C. 405(g), 1395y(a)(9), and 1395ff(b))—HEALTH INSURANCE BENEFITS—DETERMINATION—APPEALS—ENTITLEMENT

20 CFR 405.730 HCFAR–78–31c

Hamilton v. *DHEW and Blue Cross of North Dakota,* 375 F Supp 1049 (5/23/74)

The claimant sought judicial review of a final decision by the Secretary denying reimbursement for a portion of the hospital stay which created an indebtedness in the amount of Six Hundred Ninety Dollars and Fifty-five Cents ($690.55). It was determined that care during the last 10 days of the 20-day hospital stay was "custodial" in nature. The Secretary moved to dismiss on two grounds: (a) the claimant failed to commence action within 60 days after receipt of the notice and

(b) the amount in controversy failed to exceed the jurisdictional requirement of $1,000. *Held,* because the amount in controversy is less that $1,000, the court lacks jurisdiction and, therefore, the question of timeliness need not be reached. The Court also indicated that judicial review regardless of amount is available to a claimant only where the individual has been denied the right to participate in the Medicare program. Where the claim relates solely to payment for a service upon which coverage has been denied, the jurisdictional amount applies.

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[3] The patient must change to a participating facility that meets the conditions of participation if he is to be reimbursed. He has the option to remain in the facility whose provider agreement expired and was not renewed, but, he would not be reimbursed if he chose to remain. (Ed)

BENSON, Chief Judge:

During the period from October 29, 1971, through November 18, 1971, the plaintiff, Elsie B. Hamilton, was a patient at Mercy Hospital of Devils Lake, North Dakota, for treatment of multiple contusions and hypertension of her left hip. Payment for her hospitalization during the period from November 8, 1971, through November 18, 1971, was denied initially, and on reconsideration by the Secretary. On November 29, 1972, the administrative law judge held that plaintiff was not entitled to hospital benefits under Part A, Title 18 of the Social Security Act for the period of November 8, 1971, through November 18, 1971, because the care and services provided during that period were "custodial" in nature, and thus specifically excluded from coverage under § 1862(a)(9) of the Social Security Act. The plaintiff filed a request with the Appeals Council that the judge's action be reviewed. After considering all the facts, the law and regulations, the Appeals Council, on February 12, 1973, notified the plaintiff by certified mail that the administrative law judge's decision was correct and would stand as the final decision of the Secretary.

By a complaint filed on December 13, 1973, the plaintiff seeks a determination that her hospitalization from November 8, 1971, through November 18, 1971, was within the coverage provided by the defendants, and not excluded by the contract provisions. She seeks reimbursement of indebtedness to Mercy Hospital in the amount of Six Hundred Ninety Dollars and Fifty-five Cents ($690.55).

Defendant Social Security Administration, on April 22, 1974, moved to dismiss on two grounds: First, that the plaintiff failed to commence her action within sixty days after receipt by her of notice of the Secretary's decision as required by § 205(g) (42 U.S.C. § 405(g)) of the Act; and secondly, that the complaint fails to establish that the amount in controversy exceeds the $1,000.00 jurisdictional requirement of § 1869(b) of the Act, 42 U.S.C. § 1395 ff(b)(2).

Defendant Blue Cross of North Dakota, on April 25, 1974, joined in the motion to dismiss, raising the additional ground of lack of citizenship diversity between it and the plaintiff.

In 1972, Congress generally amended the conditions under which a dissatisfied individual would be entitled to a hearing by the Secretary and to judicial review of the final decision of the Secretary after such hearing. Pub. L. 92–603, Title II, § 2990(a), 86 Stat. 1464, 42 U.S.C. § 1395 ff.

In relevant part this provision is as follows:

> "(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or 426(a) of this title (provisions of eligibility for hospital insurance benefits), or
>
> (C) the amount of benefits under part A (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000."

The amended § 1395ff applies to the instant case because the action was not commenced until December 13, 1973. § 2990(b) Pub. L. 92–603 provides that the amendment shall be effective before the month of the enactment if a civil action with respect to a Secretary's final decision has not been filed before such month.

The pre-1972 statute as it provided for judicial review stated:

> 42 U.S.C. § 1395ff "(b) . . . in the case of a termination as to *entitlement* or as to *amount* of benefits where the amount in controversy is $1,000.00 or more, to judicial review of the Secretary's final decision . . . ". (Emphasis supplied)

Before the 1972 amendment, courts called upon to construe the provisions of § 1395 ff were prone to distinguish the availability of judicial review depending upon whether the dispute involved "entitlement" or "amount". *Cardno* v. *Finch*, 311 F. Supp 251 (E.D. La. 1970). This court analogized the difference to that between the question of liability and damages.

Where the issue was whether a claimant was entitled to benefits, courts tended to allow an unrestricted right of judicial review of the Secretary's decision. In *Ridgely* v. *Secretary of the Dept. of Health Ed. & Welfare*, 345 F. Supp. 983 (D. Md. 1973), the court, interpreting the pre-1972 provision, said where a person seeks review of a decision that he is not entitled to any payment for a specific service, no jurisdictional amount requirement need be satisfied. The word "entitlement" was broadly construed as dealing with whether an insured is entitled to payment in a particular case. A jurisdictional amount prerequisite was thought to exist only in cases where the *amount* of benefits one was entitled to was in issue. A common sense reading of the pre-1972 statute would support this interpretation. *See also Bohlen* v. *Weinberger*, 345 F. Supp. 124 (E.D. Pa. 1972); *aff'd* 483 F.2d 918 (3rd Cir. 1973); *Sowell* v. *Richardson*, 319 F.Supp. 689 (D.S.D. 1970).

Congress, when it amended § 1395 ff, eliminated the word "entitlement" and said that even where judicial review is sought by reason of subparagraph (C), none shall be available where the amount in controversy is less than $1,000.00. The purpose of the amendment was to clarify the original intent of the law that "entitlement" mean *eligibility* for benefits but not decisions on a claim for payment for a given service. 118 CONG. REC. 17048, 17049 (Oct. 5, 1972).

While the *Bohlen* case was concerned with the pre-1972 provisions, the appellate court in its decision did give some consideration to the effect of the amendment. In that decision the court said that Congress amended § 1395 ff in such a way that persons exerting a claim for coverage would not be entitled to administrative review. Under the 1972 version of the statute, the appellate court felt that the word "entitlement" most likely related only to the right of an individual to *participate* in the Medicare program, and not the right of an enrollee to reimbursement. 483 F.2d at 922.

On this point, Senator Bennett, the sponsor of the amendment, stated:

> "[T]he purpose of the amendment is to make sure existing law, [referring to the pre-1972 section] which gives the right of a person to go to court on the question of eligibility to receive welfare [Medicare included], is not interpreted to mean he

can take the question of the federal claim to court . . . This is to reconfirm the original intention of the law that the courts can determine only eligibility. The situations in which Medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with minor matters. The law refers to 'entitlement' as being an issue subject to court review and the word was intended to mean eligibility to any benefits of Medicare but not to decisions on the claim for payment for a given service." 118 CONG. REC. S17048, 49 (daily ed. Oct. 5, 1972).

Giving due weight to the foregoing comment, and after analysis of the statutory construction of the 1972 amendment, this Court feels it was Congress's intent to restrict judicial involvement in the kind of complaint we have before us. Judicial review unfettered by jurisdictional amount is available to a claimant only where the claim is in the overall right to participate in the Medicare program. Where it relates solely to payment for a service upon which coverage has been denied, the jurisdictional amount applies. The plaintiff, Elsie B. Hamilton, has not been denied the right to participate in the Medicare program. She was simply denied payment for a partial period of hospitalization.

Because the plaintiff's complaint indicates the amount in controversy to be $690.55, this Court, in view of the foregoing analysis, is without jurisdiction under 42 U.S.C. § 1395 ff to entertain a review.

This result being dispositive of the case, the question of timeliness need not be reached.

There existing no further federal statute upon which to base a claim, and finding there to be no diversity of citizenship between the plaintiff and Defendant Blue Cross of North Dakota, the Court is similarly without jurisdiction to entertain an independent claim against that defendant.

IT IS THEREFORE ORDERED that the motion for dismissal is granted as to both defendants.

(X—refer to SSR–75–8c)

SECTION 1815, 1861(a), and 1861(v)(1)(A)(ii) (42 U.S.C. 1395g, 1395x(a), and 1395x(v)(1)(A)(ii))—HEALTH INSURANCE-REOPENING OF AN INTERMEDIARY'S DETERMINATION ON THE AMOUNT OF PROGRAM REIMBURSEMENT AND A DECISION OF AN INTERMEDIARY PROVIDER HEARING

20 CFR 405.1885 HCFAR–78–32

Where intermediary rendered its initial determination, reopened it at a later time to correct error made in reimbursing provider; provider appealed on basis it was inequitable for an intermediary to reopen a cost report to correct its own error, *held*, regulations and general instructions require the imtermediary to correct any material errors or mistakes it may make to the extent it is not foreclosed from doing so by the 3-year limitation.

The sole issue in this appeal is the legality and propriety of the Blue Cross Plan's reopening in August 1973 of the provider's cost report for the fiscal year ended September 30, 1969, to correct its own error. The cost report was originally settled in June of 1971.

The Plan reopened the 1969 cost report to correct an error which it had

made in reimbursing the provider for its medicare deductible and coinsurance bad debts, where the hospital deductible and coinsurance charges to beneficiaries for outpatient services exceed its cost for rendering such services and exceed the Part B Supplementary Medical Insurance Benefits bad debts, the excess is to be used to reduce allowable bad debts for Part A Hospital Insurance Benefits. The Plan in settling the 1969 cost report failed to make this offset and reopened the report in 1973 to correct the error. The provider does not dispute the legality of the adjustment but contends that it is inequitable for the Plan to reopen a cost report to correct its own error.

While it is true that the reason for reopening the provider's cost report flowed from the Plan's mistake, regulations and general instructions require the Plan to correct any material errors or mistakes it may make to the extent it is not foreclosed from so doing by the 3-year limitation rule of Social Security Regulations No. 5, §405.1885(a). Basic to the successful administration of title XVIII is the concept that the fiscal intermediary will apply the law, regulations, and general instructions consistently and accurately to the cost reports of each provider. Failure to adhere to this tenet or to correct, where possible, past deviation from it would obviously result in chaotic administration of title XVIII programs. For this reason, section 405.1885(a) of Regulations No. 5, empowers an intermediary to reopen settled cost reports and section 405.1885(b) empowers the Social Security Administration to order an intermediary to reopen a settled cost report, where the intermediary settlement is inconsistent with the law, regulations, or general instructions. One of the situations requiring reopening is where an intermediary determination is found to be inconsistent with the law, regulations, and general instructions. It should be noted that reopening in such a circumstance is required without regard to whether or not the result is to increase or decrease the amount of program reimbursement due to the provider.

In this case it is clear the Plan had misapplied the law in settling the provider's 1969 cost report and that the reopening occurred within three years of the notice of determination of the amount of program reimbursement. Accordingly, the Hearing Officer affirms the reopening and the adjustments made pursuant to such reopening.

(X—refer to SSR–75–21)

SECTIONS 1861(v)(1)(A) and 1866 (42 U.S.C. 1395x(v)(1)(A) and 1395cc)—PROVIDER OF SERVICES—TRANSFER OF OWNERSHIP—REVALUATION OF ASSETS TO INCLUDE "GOODWILL" IN COMPUTING DEPRECIATION AND RETURN ON EQUITY CAPITAL

20 CFR 405.415, 405.429, 405.625 and 405.626 HFAR–78–33

The claimant appealed the intermediary's determination that acquisition of 100 percent of the capital stock of corporate provider of services did not permit revaluation of the provider's assets or the establishing of goodwill for program purposes, contending that by its acquisition of 100 percent of the capital stock, it also in effect acquired 100 percent of the corporate assets, and should be permitted to revalue the assets and include goodwill in its computation of depreciation

and return on equity capital. *Held,* the transaction constituted only the acquisiton of the corporate stock of the provider with no transfer of corporate property. Ownership of the corporate property remained vested in the corporate provider, and the intermediary's determination that revaluation of assets and establishing of good will could not be permitted was affirmed.

Under the circumstances prevailing in this case, were the Intermediary's determinations concerning adjustment of the provider's cost reimbursement report for fiscal year ending June 30, 1969, correct and in accordance with the Medicare law, regulations and instructions issued by the Social Security Administration? Specifically were those determinations correct wiht respect to:

(1) Computation and allowance of depreciation on actual cost incurred in the purchase thorugh a bona fide sale of the subject facility as an on-going business operation, and

(2) Computation and allowance of return on equity, based on actual cost incurred for such purchase?

The American Institute of Certified Public Accountants defines depreciation as a process of cost allocation:

"Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of valuation. Depreciation for the year is the portion of the total charge under such a system that is allocated to the year."

This definition, appearing in Section 104 of the Provider Reimbursement Manual (HIM–15) issued by the U.S. Department of Health, Education, and Welfare), indicates that for Medicare purposes, in order for allowances of depreciation to be applicable, there must be a demonstration that there exists property to which depreciation computations can be applied.

It is a primary contention of the claimant that by its acquisition of 100 percent of the shares of stock of a provider, it also in effect acquired 100 percent of the corporate assets or properties.

To say that a corporation is, in fact, but the sum of its stockholders, and its name but an alias for its individual corporators, is a great confusion of legal ideas. A stockholder and the corporation in which he holds stock are distinct persons in law. An owner may sell or dispose of his stock at pleasure and in doing so, works no change or modification in the title to corporate property. The owner of a share of stock owns no part of the capital of the company. The corporation is its sole owner, holding it for the purpose for which the corporation was created, and upon winding up, for the benefit of creditors and shareholders.

Basic principles of corporation law indicate that when one purchases or acquires stock in a corporation, no matter at what time, he acquires a fractional interest in the capital stock, assets, profits and liabilities of the corporation. However, by the very nature of a corporation, the corporate property is vested in the corporation itself and not in the stockholders. Concentration of stock ownership does not alter the fact that title to the corporate property is vested in the corporation, and not in the owner of the corporate stock, and even the fact that one owns all the corporate stock does not make him the owner of its property. So too, the earnings and profits of a corporation remain the property of the corporation until severed from corporate assets and distributed as dividends; until that

time, stockholders have no property interest therein.

Consequently, as a general rule, the property of a corporation is not subject to the control or disposition by its individual members or stockholders. The stockholders cannot convey or encumber such property or authorize a conveyance or encumbrance thereof on behalf of the corporation, inasmuch as the corporation must act thorugh its proper agents and in the prescribed way, and the stockholders must exercise their control over the corporation at regularly called meetings.

During the course of the hearing, considerable testimony was offered by the claimant relating to Sections 104.14 and 1214 of the Provider Reimbursement Manual. These sections, as is here pertinent, state the following:

> "104.14 *Purchase of Facility as an On-Going Operation.*—
>
> A. In establishing the historical cost of assets where an on-going facility is purchased thorugh a bona-fide sale after July 1, 1966, and prior to August 1970, the sale price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale. For depreciable assets acquired after July 1970, the cost basis of the depreciable assets shall not exceed the lower of the current reproduction cost adjusted for straight-line depreciation over the life of the assets to the time of the sale, or the fair market value of the tangible assets purchased.
>
> B. If the facility was being operated under the program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new provider in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is limited to the lower of current reproduction cost (adjusted for straight line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price.
>
> C. If a purchaser cannot demonstrate that the sale was bona fide, the lesser of the seller's net book value or sale price shall be used by the purchaser as the historical cost of the asset."
>
> "1214. GOODWILL
>
> Goodwill purchased in the acquisition of an existing orgnaization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles.
>
> However, goodwill which has not been purchased but has been internally generated as, for example, from a reorganization of the provider, is not includable in the provider's equity capital."

After careful consideration, the Panel concludes that these provisions relate to the computation of depreciation and the determination of equity capital with respect to corporate assets or property owned by the corporation itself. These provisions do not appear to have application in a situation where the only interest in the corporation is represented by ownership of corporate stock. In its deliberations, the Panel unanimously agreed that the transaction which occurred on July 1, 1968, resulted in the acquisition by the claimant, M, only of the corporate stock of the provider. The corporate property or assets were still owned by the provider. With ownership of the corporate property vested in the provider, only that legal entity, not M, could avail itself of the provisions under Section 104.14 and 1214 of the Provider Reimbursement Manual.

At the hearing, the claimant vigorously contended that a 100 percent ownership of the facility in its entirety was transferred and the mode of change is irrelevant. During its post-hearing consideration of this controversy, information was brought to the attention of the Panel that, although the claimant did acquire 100 percent ownership of the corporate

stock on July 1, 1968, the acquisition of the corporate property or assets did not occur until November 24, 1970. This transaction presents to the Panel one basic question—if, as the claimant contends, there was, in fact, a 100 percent change in ownership of the facility in its entirety, including the corporate property, on July 1, 1968, what property or interest would still remain and be available to convey to M on November 24, 1970?

The Panel further recognizes that if the corporate property of the provider had been conveyed to M on July 1, 1968, a problem would have been presented with regard to Section 405.625, Subpart F of Regulations No. 5. That section reads as follows:

> "405.625 Transfer of Provider Ownership; General.—
> (a) A transfer of ownership of a provider of services participating in the health insurance program under an agreement with the Secretary will, under the conditions discussed in §405.626, render such agreement invalid as between the Secretary and the transferee. In order for the new entity to participate in the program it must be established that it meets the conditions for participation appropriate to the hospital, extended care facility or home health agency, or rehabilitation agency or clinic, as the case may be (see Subparts J, K, and L of this Part 405) and that it meets the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 252; P.L. 88–352).
> (b) A participating provider contemplating or negotiating a change of ownership must advise the Secretary of such a contingency to assure, if the successor owner desires to participate in the program, continued payment to the hospital, extended care facility or home health agency, rehabilitation agency, or clinic on behalf of individual entitled under title XVIII of the Act."

If the July 1, 1968, transaction had resulted in a change of ownership in the corporate property, under the provisions of this regulation, the original provider's agreement with the Secretary would have been rendered invalid as to the transferee, which would have been required to meet the applicable Title XVIII conditions of participation. Since there was no recertification required or anticipated immediately subsequent to July 1, 1968, there is doubt in the minds of the panel members othat an actual change in ownership of corporate property was intended upon the acquistion of the corporate stock.

In addition, the claimant places great emphasis on its contention that in the type of transaction that occurred on July 1, 1968, the "substance" is more important than the "form" of the transaction. Based upon this premise, the claimant contended that the excess paid over book value for the provider's stock should be allocable to the provider and includable in the provider's cost report when computing depreciation and return on equity, as provided for in the Medicare regulations.

In reference to law and legal proceedings, courts have often referred to "form" as the antithesis of "substance." "Form" relates to technical details regardless of substance, while "substance" is that which is essential to the transaction.

It is the opinion of the Panel that the substance of the July 1, 1968, transaction was of such a nature that application of depreciation and return on equity guidelines are precluded. If on that date the claimant had acquired ownership of the property or assets of the provider, rather than just its corporate stock, then the "substance" of the transaction would have permitted the application of guidelines related to depreciation and return on equity. As to the return on equity question, Section

2150.4D of the Provider Reimbursement Manual specifically indicates that the home office's investment in the stock of the provider, as well as loans made to finance such investments, are not considered as elements of equity for the purpose of computing equity capital.

For the reasons stated, it is the judgment of the Hearing Officer Panel that the Intermediary properly applied the appropriate provisions of the Medicare law, the regulations issued pursuant thereto, and other instructions as those provisions relate to the facts presented by this care. Therefore, after carefully considering all the evidence presented during these proceedings and after evaluating that evidence in a light most favorable to the claimant, the panel members unanimously arrive at but one conclusion—the Intermediary's determinations must be affirmed.

(X—refer to SSR–75–22)

SECTIONS 1861(b) and 1862(a)(1) and (9) (42 U.S.C. 1395x(b) and 1395y(a)(1) and (9))—HOSPITAL INSURANCE BENEFITS—INPATIENT HOSPITAL SERVICES—LEVEL OF CARE—WEIGHT OF PHYSICIANS' OPINIONS

20 CFR 405.116 and 405.310(g) and (k) HCFAR–78–34c

Halse v. *Weinberger*, USDC Northern District of Iowa, No. C 74–2007 (12/10/74)

The 74-year-old beneficiary was a hospital inpatient from August 4 to August 26 and from September 4 to October 4, 1971, in the same hospital. Her claim for hospital insurance benefits resulted in payment for the period of August 4 to August 11 only. The claimant contested she should have received benefits for the entire period. *Held*, the claimant's condition from August 4 to August 11, 1971. was of sufficient severity to require covered inpatient hospital services, but beginning August 12 the services became custodial in nature and thus excluded under the Act. *Further held*, the examining physician's opinions are to be weighed with all evidence before the Secretary, but are not of controlling weight rather, conflicting medical testimony and inferences drawn therefrom are to be resolved by the Secretary.

McMANUS, Chief Judge:

This matter is before the court for review of a final decision made by the Secretary of Health, Education, and Welfare denying certain Medicare benefits.

Plaintiff Maggie Halse, age 74 at the time, incurred expenses while an inpatient at Winneshiek County Memorial Hospital, Decorah, Iowa, from August 4 to August 26, 1971, and again from September 4 to October 4, 1971. Upon filing a claim for Medicare benefits under Title XVIII of the Social Security Act, 42 U.S.C. §1394 *et seq.*, payment of hospitalization benefits under Part A of Title XVIII was initially made by the intermediary insurance carrier only for the period August 4 to August 11, 1971.

This determination was upheld after reconsideration on April 10, 1972. Plaintiff's son thereupon requested a hearing before an administrative law judge, who held said hearing in Waterloo and issued an order on

August 29, 1973, declaring the expenses for the full term of forty-four days of hospital confinement payable under the Act.

On its own motion, the Appeals Council reviewed the Hearing Examiner's decision and reversed his conclusions, thereby reinstating the initial administrative determination to allow payment for only the August 4 to August 11 hospitalization costs. Plaintiff asks the court to review the decision of the Appeals Council pursuant to 42 U.S.C. §1395ff(b)(1)(e) since the amount in controversy exceeds $1000.00.

The central issue to be resolved in the administrative hearings was whether plaintiff's hospital care for the periods August 12 to August 26 and September 4 to October 4 was "inpatient hospital services" as defined in 42 U.S.C. §1395 x(b) and 20 CFR 405.116, or was merely "custodial care" excluded from coverage by 42 U.S.C. §1395y(a)(9) and 20 CFR 405.310(g). The Appeals Council concluded that only the treatment furnished plaintiff from August 4 to August 11 required the constant availability of hospital medical personnel and facilities so as to constitute inpatient medical services.

The court's function in reviewing a final decision by the Secretary denying reimbursement of hospital expenses under Part A of Title XVIII, as with judicial review of other final decisions under the Act by the Secretary, is prescribed in §205(g), 42 U.S.C. §405(g). *Johnson* v. *Richardson*, 336 F. Supp. 390, 391 (E.D. Pa. 1971). The court's role is limited solely to ascertaining whether the Secretary's determination is supported by substantial evidence. *Brasher* v. *Celebrezze*, 340 F.2d 413 (8th Cir. 1964); *Delk* v. *Richardson*, 365 F. Supp. 627 (D. S.C. 1973); *Johnson* v. *Richardson*, *supra*; *Reams* v. *Finch*, 313 F.Supp. 1272 (N.D. Ia. 1970), *aff'd*, 428 F.2d 1225 (8th Cir. 1970).

The legal standards generally applicable in review actions of this type were summarized in *Brasher*, *supra* at 414:

> [A] the claimant has the burden of establishing his claim: (b) the Act is remedial and is to be construed liberally; (c) the Secretary's findings and the reasonable inferences drawn from them are conclusive if they are supported by substantial evidence; (d) substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion; (e) it must be based on the record as a whole; (f) the determination of the presence of substantial evidence is to be made on a case-by-case basis; (g) where the evidence is conflicting it is for the Appeals Council on behalf of the Secretary to resolve those conflicts: . . .

The Appeals Council concluded, inter alia, as follows:

> We find that as of August 12 and on readmission September 4, that all the medical evidence of record reveals no basis for disputing the prior determination that the claimant received general institutional care. A review of the records confirms that claimant received only minimal treatment consisting of diet, oral medication and bed rest. While the record shows during some days she was experiencing some pain and restlessness, no remarkable medical treatment was instituted, or change of orders was found to be necessary to relieve said condition. (Tr. p. 7.)

The court recognizes that less weight need be given to the Appeals Council's findings when it rejects the Hearing Examiner's findings than when it sustains the latter, and that the Hearing Examiner's report must be consulted to determine substantiability of the evidence. *Universal*

Camera Corp. v. *N.L.R.B.*, 340 U.S. 474, 491–97, 71 S.Ct. 456, 95 L.Ed. 456 (1951); *Tucker* v. *Celebrezze*, 220 F.Supp. 209, 211 (N.D. Ia. 1963). The Hearing Examiner placed primary reliance upon written comments made by Dr. Larson, the attending physician, who did request that the Secretary allow plaintiff's total hospitalization claim. (Tr. p. 28.)

The record discloses that two other physicians, who reviewed plaintiff's medical history but did not personally examine her, decided that her hospital treatment from August 12 thenceforth was of a custodial nature. (Tr. pp. 28, 65, 113, 179.) The examining physician's opinions are not of controlling weight in Medicare cases because of the potential personal interest which might be at stake on the physician's part. *Weir* v. *Richardson*, 343 F.Supp. 353, 357 (S.D. Ia. 1972). See *Johnson* v. *Richardson*, *supra* at 394–95. Rather the attending doctor's statements are properly weighed against all other evidence before the Secretary.

Reviewed in this light, it is the court's view that the decision of the Appeals Council is supported by substantial evidence. Conflicting medical testimony and inferences drawn therefrom are to be resolved by the Secretary. *Martin* v. *Finch*, 415 F.2d 793 (5th Cir. 1969); *Dixon* v. *Gardner*, 406 F.2d 1035 (4th Cir. 1969); *Johnson* v. *Richardson*, *supra*.

Plaintiff was suffering from several chronic conditions, including osteoarthritis, stroke residuals, and parkinsonism, when initially admitted to the hospital on August 4. At that time she also exhibited a urinary infection, but this infection was cleared up by August 12. Plaintiff was reimbursed for her expenses up to this point.

Thereafter she received oral medications, soft diet, routine lab tests, and physical assistance in walking and other activities, but no specialized medical treatment or physical therapy which would qualify her care as inpatient services. *See Johnson* v. *Richardson*, *supra*. *Cf. Schoultz* v. *Weinberger*, 375 F.Supp. 929 (E.D. Wis. 1974).

The attending physician's progress notes indicate that plaintiff was readmitted to the hospital on September 4 for "nursing care" and had been specifically advised that Medicare might not cover her hospitalization expenses. (Tr. p. 123.) The same notes state that her "general condition [was] about same" on September 30. (Tr. p. 124.) While both the physician's and the nurses' comments show that plaintiff's emotional state varied considerably from day to day, no acute physical problems or treatment thereof is apparent from the notes.

The court sympathizes with the debilitating effects of plaintiff's chronic illnesses and the financial strain which her plight places upon family financial resources, but the Medicare program was designed to reimburse only expenses for the sophisticated health services which *must* be rendered by skilled professional personnel. The evidence before the Appeals Council reasonably supports their conclusion that benefits should be denied for the period indicated.

It is therefore

ORDERED

The decision of the Secretary is affirmed.

(X—refer to SSR–75–29c)

SECTIONS 1102, 1861(v), and 1871 (42 U.S.C. 1302, 1395x(v), and 1395hh)—HEALTH INSURANCE BENEFITS—INTERMEDIARY'S INSTRUCTIONS TO PROVIDERS

20 CFR 405.451 HCFAR–78–35c

New Jersey Chapter Incorporated of the American Physical Therapy Association, Inc. v. *The Prudential Life Insurance Company of America, et al.*, 502 F.2d 500 (D.C. Cir., 1974), *cert. denied*, 95 S. Ct. 1444 (1975), 43 LW 3453

The Social Security Administration issued instructions to the intermediary concerning identification of unreasonable costs and the application of the "prudent buyer" policy. The intermediary, in turn, sent to its participating extended care facilities a letter containing guidelines for evaluating the reasonableness of costs incurred by providers for physical therapy services under this prudent buyer policy. The Association requested the instructions be retracted because of noncompliance with the rule-making procedures of the Administrative Procedure Act. *Held*, the letter from the intermediary was not a regulation but was merely an explanation or interpretation of the reasonable cost limitation found within the Medicare Act. The intermediary's use of guidelines, such as those outlining the method for determining "reasonable costs", is within the authority conferred by the Act and regulations.

ROBB, Circuit Judge:

This action arises under the Health Insurance for the Aged Act, 42 U.S.C. §§1395 *et seq.*, commonly known as the Medicare Act.

The Secretary of Health, Education and Welfare is charged with the administration of the Act, and he has delegated this authority to the Commissioner of the Social Security Administration. Within the Social Security Administration the Bureau of Health Insurance has the primary responsibility for administering the Act. The statutory scheme "provides basic protection against the costs of hospital and related post-hospital services . . . for individuals who are age 65 or over" and are entitled to benefits under the Act. 42 U.S.C. §1395c. Beneficiaries are entitled to receive services covered by the Act from hospitals, extended care facilities or home health agencies which are qualified to participate in the program. These institutions are called "providers of services" or providers. 42 U.S.C. §1395x(u); 42 U.S.C. §1395cc. They are entitled to be reimbursed for the reasonable cost of the services they provide to beneficiaries. 42 U.S.C. §1395f. Under the Act providers may elect to have payments to them made through a private organization and the Secretary is authorized to make contractual arrangements with such an organization to act as the fiscal intermediary between the providers and the government. When this is done, the intermediary determines the amount and reasonableness of the payments to be made to providers. 42 U.S.C. §1395h.

The appellant association, plaintiff in the District Court, is an association of physical therapists who are licensed to practice physical therapy in the State of New Jersey. Many of the association's members are private practitioners of physical therapy who have contracted to supply services to providers under the Act. Prudential Insurance Company, a defendant in the District Court, was selected by many of the qualified extended care facilities in New Jersey to serve as their fiscal intermediary, and Pruden-

tial has been acting in that capacity.

In August 1969 the Bureau of Health Insurance issued Intermediary Letter No. 393 (IL–393). This letter, captioned "SUBJECT: Identifying unreasonable costs—application of the 'prudent buyer' concept" stated in part:

> Several cases have come to our attention that suggest that it may be helpful to provide some reminders on a number of areas that involve identifying reasonable costs. This letter outlines some of the steps which intermediaries should be taking to protect the program against making reimbursement for amounts which are in excess of what a prudent and cost-conscious buyer would pay for a given item or service.
>
> * * * *
>
> It is not expected, for example, that reimbursement will be based on costs arising from a provider paying at individual rates for physical therapy which is provided by a single therapist to groups of patients simultaneously.

In October 1971 the Bureau sent to all intermediaries a draft of a proposed intermediary letter (IL–71). This letter stated in part:

> This letter establishes guidelines for intermediaries to follow in determining the reasonableness of the costs a provider incurs in furnishing physical, occupational, inhalation or speech therapy to program beneficiaries under arrangements with self-employed therapists. The basic measure of reasonable cost for the service of nonemployee therapists is the amount of salary or wages that is paid to employee therapists in the area performing similar functions and is intended to protect the program against reimbursing for costs in excess of what a prudent and cost-conscious buyer would pay for the services. This amount is adjusted to take into account the normal fringe benefits of full-time employees of the provider, as well as reasonable expenses incurred by a part-time nonemployee therapist. Where applicable, these rules apply to other health specialists providing services under arrangements.
>
> I. *Prudent Buyer Concept*
>
> Providers are expected to be prudent and cost-conscious purchasers of arranged-for therapy services. In applying this concept, the following situations are presumptively indicative of unreasonable costs: (1) costs incurred for the services of an independent contractor are in excess of what would have been the provider's costs of furnishing the same services had it employed a therapist . . . .

A copy of the proposed IL–71 was sent to the American Physical Therapy Association on October 27, 1971 with a request that the association submit its written comments or recommendations no later than November 15, 1971. Proposed Intermediary Letter No. 71 has never been made final.

On November 23, 1971 Prudential sent to "MEDICARE PARTICIPATING EXTENDED CARE FACILITIES" a letter on the subject of "REIMBURSEMENT FOR SERVICES OF NON-SALARIED THERAPISTS." The letter stated in part:

> Public Law 89–97 provides that reimbursement to providers for covered services rendered to Medicare beneficiaries shall be on the basis of reasonable cost. In fulfilling our responsibility as an intermediary, we must identify unreasonable costs and take steps to protect the program from reimbursing for costs in excess of those which a prudent and cost-conscious buyer would incur.
>
> The implementation of this policy for physical, speech, occupational, and inhala-

tion therapy services rendered by non-salaried therapists in an institutional setting involves two major considerations. They are:

1. Payment for the cost of these services shall not exceed an amount equal to the salary which would have been payable if the services had been performed by an employee, plus the cost of such other reasonable expenses as may be incurred by independently contracting therapists (e.g., travel time, salaries of aides).
2. Payment for the cost of these services will be based upon the reasonable time spent in performing them.

In order that this policy can be effectively carried out, it will be necessary that accurate records of the therapists' activities be maintained and made available to the intermediary. Accordingly, effective January 1, 1972, the provider will be responsible for the maintenance of a daily log showing the names of all patients treated and the total daily time spent by the therapist including time spent in the supervision of aides and/or non-qualified therapists) . . . . In the absence of a properly maintained log, no Medicare reimbursement for these therapy services will be allowed.

* * * * *

Because allowable reimbursement for the services of therapists is to be based on a salary equivalent, we should know the details of your arrangements with contracting therapists. *Our measurement* of the reasonableness of the cost of these services will be based on hourly rates of pay for both the therapists and their aides, if any. . . .

In order to avoid the possibility of having a portion of your therapy costs disallowed as excessive, we strongly recommend that you negotiate arrangements with your non-salaried therapists to provide for their compensation on a time basis and that the results of such negotiations be submitted to us for review well in advance of the effective date of January 1, 1972. [emphasis in original.]

In a letter to providers dated April 12, 1972 Prudential clarified the intent of its letter of November 23. The letter of April 12, 1972 stated in part:

As you know, Intermediary Letter 393 issued on August 1969 [sic], and Provider Reimbursement Manual section 2103, set out the concept of the prudent buyer; that is, a provider is a prudent buyer if it not only refuses to pay more than the going price for an item or service, but also seeks to economize by minimizing costs. The purpose of these program statements is to assist all parties in identifying reasonable costs and to help prevent incurring unreasonable costs.

It should be noted that our previous letter indicated the establishment of guideline criteria for evaluating the reasonableness of the cost of therapy services and was not intended as a maximum for payment. Providers incurring costs in excess of our guidelines will be given an opportunity to show that they were acting as prudent buyers when incurring the cost. However, the burden of proof of the reasonableness of the costs does lie with the provider.

In March 1972 the plaintiff association commenced this action against Prudential, the Secretary of HEW, and various HEW officials. The action sought: (1) a preliminary injunction, enjoining the defendants from effectuating the standards and guidelines for reimbursement of non-salaried physical therapists as expressed in the Prudential letter and IL–71; (2) a declaratory judgment that the Prudential letter and IL–71 "are null and void"; (3) that Prudential be required retroactively to adjust any reimbursements made pursuant to its salary equivalent standard so that physical therapists who were paid in accordance with that standard would be paid in accordance with the standard prevailing prior to January 1, 1972; and (4) that Prudential be required to retract its letter because of non-compliance with the rulemaking procedures of the Administrative Procedure Act.

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Citing *Association of Data Processing Service Organizations, Inc.* v. *Camp*, 397 U.S. 150 (1970), the District Court dismissed the complaint on the ground that the interests of the plaintiff were not "arguably within the zone of interests to be protected" by the Health Insurance for the Aged Act. The court considered that although some of the plaintiff's members might be economically affected by the Prudential letter, the plaintiff's interest was "to remote to the interests protected under the Act".

On this appeal the government argues (1) plaintiff's complaint does not state a meritorious claim for relief; (2) the District Court correctly held that plaintiff did not have standing to sue; and (3) determination of the amounts payable to providers of services is not subject to judicial review. We turn first to the government's second and third arguments.

The government says correctly that the Act was expressly designed for the protection of elderly citizens who require medical care, and those persons of course have standing to vindicate their rights under the Act. Furthermore, since the Act assures a provider of reimbursement for the reasonable costs incurred by him, a provider would seem to have an interest within the zone protected by the statute. Plaintiff's members on the other hand are not subject to regulation under the Act and their rights are derived from their contractual arrangements with providers. There is nothing in the Medicare Act or its legislative history, says the government, which indicates any concern by Congress to protect the interests of persons such as plaintiff's members who are only indirectly affected by the operation of the Medicare program. From all this the government concludes that the plaintiff and its members have no standing to sue.

In support of its argument that the plaintiff's claims are not subject to judicial review, the government directs our attention to the provisions of the Medicare Act, 42 U.S.C. §1395ff, which provide for judicial review of (1) a determination of whether an individual is entitled to benefits and a determination of the amount of benefits, and (2) a determination that an institution is not a provider of services or that its agreement to provide services should be terminated. The government finds it significant that no provision is made for judicial review of the award of compensation to providers of services; and the government reasons that since decisions on this matter are not subject to judicial review it follows *a fortiori* that decisions on the amounts due to contractors, who are indirectly affected by the Medicare program, are also not subject to judicial review.

There is much force in the government's arguments. As this court has said however recent decisions of the Supreme Court "have made the standing obstacle to judicial review a shadow of its former self, and have for all practical purposes deprived it of meaningful vitality." *National Automatic Laundry & Cleaning Council* v. *Shultz*, 143 U.S. App. D.C. 274, 278, 443 F.2d 689, 693 (1971). Standing need not be founded on a rock; a pebble or even a cobweb may do. Moreover , only a showing of clear and convincing evidence of legislative intent will justify a court in precluding access to judicial review. *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967); *Barlow* v. *Collins*, 397 U.S. 159 (1970). Here, we think plaintiff's standing and the reviewability of plaintiff's claims at least present close and difficult questions; but we shall not pause to wrestle with these problems, since we conclude that in any event the defendants must prevail on the merits.

The Act explicitly limits the reimbursement of "providers" to the "reasonable cost" of the services rendered to Medicare beneficiaries. 42 U.S.C. § 1395f(b). As a fiscal intermediary making reimbursement to providers, therefore, Prudential is bound to apply the reasonable cost standard to claims submitted by providers. In fulfillment of its obligation, and in accord with HEW's "prudent buyer" concept, Prudential issued its letter of November 23, 1971. We think this letter was a reasonable and proper attempt to outline a rational method for determining "reasonable costs". We think also that Prudential's use of guidelines of this type is within the authority conferred by the Act and HEW's regulations.

Although the plaintiff contends that the Prudential letter sets a "ceiling" on costs and thereby permits Prudential to disallow "reasonable costs" it is plain to us that Prudential will continue to allow all costs that are reasonable. Prudential's letter of April 12, 1972 explicitly stated:

> Providers incurring costs in excess of our guidelines will be given an opportunity to show that they were acting as prudent buyers when incurring the cost. However, the burden of proof of the reasonableness of the costs does lie with the provider.

Thus, the effect of the guidelines is to provide for automatic payment of physical therapy costs when they do not exceed the adjusted rate charged by salaried therapists; for the provider incurring such costs has clearly acted as a "prudent buyer". If the costs exceed these amounts, however, Prudential requires the provider to demonstrate that the additional costs are reasonable. In other words the guidelines establish a level of costs which Prudential will pay without additional proof of their reasonableness.

The plaintiff contends that Prudential promulgated a "regulation" without the notice and opportunity for comment required by the Administrative Procedure Act. 5 U.S.C. §553. We think the argument has no merit. Without intimating that Prudential is an "agency" within the meaning of the Act, 5 U.S.C. §551(1), we hold that Prudential's letter was not a regulation but was merely an explanation or interpretation of the reasonable cost limitation found in the Medicare Act. *Cf.* 5 U.S.C. §553(b)(A).[1]

The judgment is

Affirmed.

(X—refer to SSR–75–30c)

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[1] Plaintiff's complaint was filed March 22, 1972. On October 30, 1972, by amendment to the Social Security Act, Congress provided that the salary equivalent standard should apply to payments for physical therapy services. P.L. No. 92–603, 86 Stat. 1445; 42 U.S.C. §1395x(v)(5). The plaintiff suggeststhat this action demonstrates that Prudential's guidelines were previously unauthorized by the Act. We do not agree. " 'Public policy required that agencies feel free to ask legislation which will terminate or avoid adverse contentions and litigations.' " *FTC* v. *Dean Foods Co.*, 385 U.S. 597. 610 (1966), *citing Wong Yang Sung* v. *McGrath*, 339 U.S. 33, 47 (1950).

SECTION 1861(a) and (b)—HOSPITAL INSURANCE BENEFITS—DURATION OF SPELL OF ILLNESS—INPATIENT HOSPITAL SERVICES

20 CFR 405.110 HCFAR–78–36

This ruling supersedes SSR 70–25 (with the exception of the penultimate paragraph, this ruling is a reprint of SSR 70–25.)

A hospital insurance beneficiary with several periods of hospitalization beginning March 13, had been discharged from the hospital on May 3 and was readmitted for treatment of the same condition on July 24. In the interim, on June 27, she reported to the hospital's outpatient clinic for treatment of an unrelated condition, but because of the doctor's delay, she was admitted to the hospital and was furnished 1 day of inpatient hospital care. *Held,* since she did not remain out of the hospital for a period of 60 consecutive days between her discharge on May 3 and the admission of July 24 as required by section 1861(a) of the Social Security Act, her readmission to the hospital on July 24 did not start a new spell of illness but was a continuation of the original spell of illness which began on March 13.

Section 1812(a) of the Social Security Act defining the scope of hospital insurance benefits, provides that an individual entitled to such benefits is eligible to have payment made on his behalf for up to 150 days [1] of inpatient hospital services during any spell of illness, defined as follows in section 1861(a) of the Act:

***a period of consecutive days—(1) beginning with the first day not included in a previous spell of illness (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under Part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.

R, a hospital insurance beneficiary, had several periods of hospitalization beginning in March 1969, as follows: March 13 through April 3, a period of 21 days; April 7 through May 3, 26 days; July 24 through August 23, 30 days. Between her discharge from the hospital in May and her readmission in July, R had to report to the outpatient department of the hospital to have a small growth removed. Because of unavoidable delay, the doctor could not attend to this matter on the day R reported, and advised her to stay overnight in the hospital, the night of June 27–28.

R's hospital bill contained a charge of $198, representing the coinsurance amount of $11 for each day beginning August 5, which was the 61st day of inpatient hospital services used by R in the spell of illness which had begun when she was first admitted to the hospital on March 13, 1969,

[1] The beneficiary has 90 days coverage for inpatient hospital services in any spell of illness (benefit period); he also has a "lifetime reserve" of 60 additional days of inpatient hospital services on which he may draw after he has exhausted 90 days in a benefit period (unless he specifically elects not to use them).

according to the hospital's records.[2] R has protested the coinsurance charge, stating that her current spell of illness (benefit period) had actually begun on July 24, when she was readmitted to the hospital for a month's stay, and that no coinsurance amount was therefore due. The basis for this protest was that she did not consider the overnight stay in the hospital as inpatient care, and therefore it should not interrupt the out-of-hospital period of more than 60 days from her discharge on May 3 to her readmission on July 24.

The issue to be resolved here is whether a new spell of illness, as defined in section 1861(a) supra, began on July 24, 1969, with R's readmission to the hospital, or whether such readmission occurred within the initial spell of illness begun on March 13, 1969, so as to make R liable for payment of the coinsurance amount of $198 for which she was billed. This in turn depends on whether or not R was furnished services as an inpatient of the hospital on June 27.

Section 1861(b) of the Act provides, as pertinent here, that the term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital . . . by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital. . . .

excluding however—

* * * *

(4) medical or surgical services provided by a physician, resident, or intern; and

(5) the services of a private-duty nurse or other private-duty attendant.

* * * *

The file contains the following statement from R's physician:

During the interval between her dismissal of May 3, and her readmission on July 24, she developed a small growth on the neck, and was advised to have it removed in the outpatient department (6/27) of [S] Hospital. Due to unavoidable delays on my part it was quite late before I was able to attend to the removal of this growth, and for this reason I advised her to remain in the hospital overnight. There was nothing in her condition which would have necessitated her remaining in the hospital. This overnight stay was strictly on the basis of the lateness of the hour.

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[2] Under section 1813 of the Act, a hospital insurance beneficiary is responsible for payment of a coinsurance amount for each day of inpatient hospital services used from the 61st through the 90th day during any spell of illness (benefit period). With respect to a spell of illness beginning in 1969, any payment made under the program on behalf of a hospital insurance beneficiary is subject to reduction as follows: a deductible of $44, a coinsurance amount of $11 for each day from the 61st through the 90th day of covered inpatient hospital services used, and a coinsurance amount of $22 for each reserve day used from the 91st through the 150th day during that spell of illness.

The evidence in this case, which is not in dispute, also shows that R was in fact admitted to the hospital for the one day in question. While it is true that the physician stated that the services rendered were originally scheduled to be performed in the hospital's outpatient department and that R's admission to the hospital for an overnight stay was due to the lateness of the hour, R was in fact admitted to the hospital and received one day of inpatient hospital care. The fact that the inpatient services received were either covered or excluded from coverage is irrelevant in the determination of whether or not they would serve to extend the spell of illness. It is only relevant that the beneficiary was admitted as an inpatient.

Since R's stay in the hospital beginning June 27 was as an inpatient receiving inpatient hospital services, it is *held* that a new spell of illness did not begin with her readmission to the hospital on July 24, since there had not elapsed a period of 60 consecutive days in the initial spell of illness (which began March 13) on each of which she was not an inpatient of a hospital, as required by section 1861(a) of the Social Security Act. *Held further,* since only one spell of illness is involved, beginning March 13, R is responsible for payment of the coinsurance amount of $198 for which the hospital billed her, representing $11 for each day beginning with the 61st day of inpatient hospital services used by R in that benefit period.

(X—refer to SSR–76–16)

SECTIONS 1814(a)(3), 1861(b), 1861(e), and 1862(a)(1) (42 U.S.C. 1395f(a)(3), 1395x(b) and (e), and 1395y (a)(1))—HOSPITAL INSURANCE BENEFITS—REASONABLE AND NECESSARY SERVICES—TEAM APPROACH IN REHABILITATION SERVICES

20 CFR 405.310(g) and 405.310(k) HCFAR–78–37a

(With the exception of the deletion of references to reevaluation, this is a reprint of SSR 74–34a(89).)

> Where following a cerebrovascular accident with right hemiplegia and aphasia, claimant for hospital insurance benefits required and received as an inpatient of a rehabilitation hospital intensive rehabilitation services requiring a multi-disciplinary coordinated team approach to upgrade her ability to function as independently as possible, *held*, payment may be made since such services were required to be given on an inpatient hospital basis and were therefore reasonable and necessary for treatment of claimant's illness.

W, the claimant, was admitted to Hospital A on September 23, 1970, with a sudden onset of aphasia and right-sided hemiplegia, and remained there during the acute period of her illness. On October 19 she was transferred to X Rehabilitation Hospital where she remained until discharged on December 19, 1970.

At issue is whether payment may be made on W's behalf for the services furnished her by the X Rehabilitation Hospital for the period October 19, 1970, to December 19, 1970. The specific issue is whether it was medically necessary for her to receive treatment or diagnostic study as an inpatient in a hospital.

Section 1814 of the Social Security Act provides in part:

> (a) Except as provided in subsection (d), payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—
>
> * * * *
>
> (3) with respect to inpatient hospital services . . . which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose . . .

Section 1861(b) of the Act defines the term "inpatient hospital services" as the following items and services furnished to an inpatient of a hospital and by the hospital—

> "(1) bed and board;
>
> "(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and
>
> (3) such other diagnostic or therapeutic items or services, furnished by the hospital, or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

Section 1861(e) of the Act defines the term "hospital" as an institution which—

> (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

Upon admission to X Hospital, the physical examination rendered an impression of cerebrovascular accident with right hemiplegia, aphasia, and hypertention. On October 22 W was examined by a member of the hospital's Department of Physical Medicine and Rehabilitation. His general findings show that she was totally aphasic with poor trunk balance and rightsided hemiplegia with right facial palsy.

Her first speech therapy evaluation was done October 23, 1970. The therapist felt prognosis for return of functional language was poor; however, she felt a trial period of therapy was warranted because of the inconsistent comprehension and the recent occurrence of the cerebrovascular accident. The claimant was scheduled for daily speech therapy and responded well to the first week of therapy. It is noted that at the time of evaluation her speech was usually limited to "yeh," but at the end of the first week, she was able to read words aloud and repeat a sentence although there were articulation errors. A marked change in alertness and general physical condition after 2 weeks of therapy suggested a need for reevaluation. This was done November 10 and 11, and she showed improvement in auditory comprehension and increased verbalization.

The initial physical therapy evaluation shows the claimant needed much assistance in wheelchair management. She could come to a standing position in the parallel bars with assistance but required the assist-

ance of two people to ambulate on them. Her balance in a standing position was only fair, which appeared to be related to muscle weakness rather than a real balance problem. A continued program of gait training was instituted. The physical therapy discharge summary indicates the claimant received physical therapy from October 21 to December 18, 1970, consisting of tilt table and progressing to ambulation. At the time of discharge, she ambulated up to 40 feet with the aid of a four-pronger cane and supervision. She required some assistance ascending and much assistance descending stairs. Difficulty getting out of her wheelchair persisted, but she could accomplish this with assistance.

An occupational therapy self-care evaluation was done on October 22, 1970. Her level of performance indicated almost total dependence; however, a self-care program including wheelchair transfers, eye-hand coordination, passive range of motion and active exercises where needed was instituted. Slow but steady progress was noted on November 3. In addition, the claimant expressed a desire to look better; therefore, it was decided to have her begin work on make-up application. By November 18 she could ambulate in physical therapy with the aid of a walker and moderate assistance. By December 10 she still needed assistance with dressing upper and lower extremities, but wheelchair transfers had improved. The occupational therapy discharge summary indicates the claimant had become capable in feeding herself, she required supervision in grooming and bathing, she could dress herself for the most part, and she needed supervision in wheelchair transfer.

A patient is considered to require a hospital level of inpatient care if he needs a relatively intensive rehabilitation program consisting of a multidisciplinary coordinated team approach to upgrade his ability to function as independently as possible. A program of this scope usually includes intensive skilled rehabilitation nursing care, physical therapy, occupational therapy and, if needed, speech therapy. Upon admission, an assessment should be made of the patient's medical condition, attitude toward rehabilitation, functional limitations and prognosis. A decision should then be made whether rehabilitation is possible, what reasonable goals are, and how these goals are to be achieved. There need not be an expectation of the attainment of complete independence in the activities of daily living but there must be an expectation of an improvement that would be of a practical benefit to the patient.

It is noted that the claimant spent 26 days at the initial hospital where she was treated during the acute stage of her illness due to a cerebrovascular accident which resulted in right hemiparesis and aphasia. The attending physician felt the claimant was a good candidate for rehabilitation as evidenced by his certification and recertification, and his statement dated September 20, 1971. He had the claimant transferred to the X Rehabilitation Hospital for specialized rehabilitation care.

(X—refer to SSR–76–26a)

SECTION 1869(b) (42 U.S.C. 1395ff(b))—HOSPITAL INSURANCE BENEFITS—RIGHT TO JUDICIAL REVIEW—CONTESTED AMOUNT LESS THAN $1000

20 CFR 405.730

Rubin v. *Weinberger*, 524 F.2d 497 (7th Cir. 1975) HCFAR–78–38c

The claimant, having been hospitalized from June 11 through July 17, 1971, sued to recover $722 in hospital insurance benefits. The initial determination of the Secretary denied claimant $1,130.12 in hospital benefits for the period from July 1 to July 17. On appeal the Administrative Law Judge allowed 6 additional days of hospital insurance benefits, amounting to $408. Subsequently, the Appeals Council denied further review. Claimant then sought judicial review in a United States district court, which dismissed the action for lack of jurisdiction, determining the amount in controversy to be less than $1,000. On appeal, the Court of Appeals *held* that section 1869(b) of the Social Security Act limits judicial review of the Secretary's final decisions as to the proper amount of disputed Medicare benefits to cases where amounts in controversy are $1,000 or more, and that the Secretary's decision in the instant case was final after the Appeals Council's refusal to review, at which time the amount in controversy was $722. *Further held*, the denial of judicial review in such cases does not violate due process or equal protection under the law because Congress excluded judicial review in such cases on a rational basis—i.e., to avoid overburdening the courts.

CUMMINGS, PELL, AND BAUER, Circuit Judges:
Per Curiam

This appeal presents the question whether the district court had jurisdiction over a claim for Medicare benefits where the amount remaining in controversy is less than $1,000.

In April 1974, plaintiff filed her action under the Social Security Act seeking to recover hospital benefits for the period July 7, 1971, through July 17, 1971, in the amount of $722. Plaintiff had been hospitalized from June 11 until July 17 for the treatment of various ailments. The initial decision of the Secretary of Health, Education and Welfare on September 28, 1971, denied plaintiff $1,130.12 in hospital benefits for the period July 1, 1971, to July 17, 1971. On appeal, the Administrative Law Judge allowed six additional days of hospitalization benefits, amounting to $408; his decision became final when the Appeals Council of HEW denied further review on February 28, 1974.[1] The district court granted the Secretary's motion to dismiss for lack of jurisdiction. We affirm.

On October 30, 1972, Congress amended the pertinent provision of the Social Security Act to limit judicial review of the Secretary's "final decision" of the proper amount of disputed Medicare benefits to cases where

[1] The action of the Appeals Council is the final step in the administrative review of the denial of benefits (20 CFR § 404.951) and constitutes the final decision of the Secretary. See 20 CFR § 422.210.

the amounts in controversy exceed $1,000.[2] Having been enacted prior to the filing of the present lawsuit, this amendment controls. *Cort* v. *Ash*, 422 U.S. 66, 76–77, 95 S.Ct. 2080, 45 L.Ed.2d 26. Indeed Congress specifically provided that the amendment is to govern claims filed in district courts after October 1972. Pub.L. No. 92–603, § 299*O*(b), 86 Stat. 1329. Therefore, whether this statute bars review depends upon a determination of the amount in controversy at the time of the suit. Section 1869(b) of the Social Security Act provides that judicial review can be sought only from a final decision of the Secretary (n. 2 *supra*). By regulation, the Secretary has provided that a decision shall be final after review by the Appeals Council. 20 CFR § 405.730. This occurred on February 28, 1974, and at that time the amount in controversy was about $722. The district court properly granted the Government's motion to dismiss. *Hamilton* v. *Blue Cross of North Dakota*, 375 F. Supp. 1049 (D.N.D.1974); *Wager* v. *Secretary of HEW*, CCH Medicare and Medicaid Guide ¶ 26,780.816 (S.D.N.Y.1973).

Plaintiff contends that the Administrative Law Judge's reduction of her original claim from $1,130.12 to $722 divested her right to judicial review granted by Congress. The contention is without merit because the statutorily granted right to judicial review vested only after final decision by the Secretary. See note 2 *supra;* see also 42 U.S.C. § 405(g).[3]

It is well settled that federal district court's possess only the jurisdiction that Congress has conferred upon them. *South Carolina* v. *Katzenbach*, 383 U.S. 301, 331, 86 S.Ct. 803, 15 L.Ed.2d 769; *Glidden Co.* v. *Zdanok*, 370 U.S. 530, 551, 82 S.Ct. 1459, 8 L.Ed.2d 671; cf. *Weinberger* v. *Salfi*, —— U.S. ——, 95 S.Ct. 2457, 45 L.Ed.2d 522. Plaintiff, however, contends that in this case the foreclosure of judicial review for claims such as hers violates the due process clause. Congress excluded judicial review of the amount of benefit claims under $1,000 to avoid overburdening the

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[2] Section 1869(b) of the Social Security Act provides as follows:

"(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

"(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

"(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of Part B of this title, or section 1818, or section 1819, or

"(C) the amount of benefits under Part A (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000." (42 U.S.C. § 1395ff(b))

This amendment resolved certain difficulties of construction that prevailed under the previous language of Section 1869. See *Cardno v. Finch*, 311 F. Supp. 251 (E.D. La. 1970); *Ridgely v. Secretary of H. E. W.*, 345 F. Supp. 983 (D. Md. 1972), affirmed, 475 F.2d 1222 (4th Cir. 1973); *Bohlen v. Richardson*, 345 F. Supp. 124 (E.D. Pa. 1972), affirmed, 483 F.2d 918 (3d Cir. 1973).

[3] Were plaintiff contending that the Administrative Law Judge and the Appeals Council acted arbitrarily for the purpose of denying plaintiff judicial review, jurisdiction might be found on the basis of Section 10 of the Administrative Procedure Act (5 U.S.C. §§ 701–706; see *Sanders v. Weinberger*, 522 F.2d 1167 (7th Cir. 1975)) or under the Mandamus and Venue Act (28 U.S.C. § 1361). See *Peoples v. United States*

courts (see 118 Cong.Rec. 17,048–17,049 (daily ed., Oct. 5, 1972)); because a rational justification exists for this limitation, it is constitutional. See *United States* v. *Kras*, 409 U.S. 434, 446–447, 93 S.Ct. 631, 34 L.Ed.2d 626; *Dandridge* v. *Williams*, 397 U.S. 471, 484–485, 90 S.Ct. 1153, 25 L.Ed.2d 491.

The brief of *amicus curiae* suggests that the district court had jurisdiction to hear this matter as a mandamus action under 28 U.S.C. § 1361 to require the Administrative Law Judge to state reasons for denying plaintiff's claim. Since this ground was not advanced below, it comes too late for our consideration. In any event, the Administrative Law Judge explained that plaintiff was only entitled to coverage through July 6, 1971, because thereafter she had recovered sufficiently to leave the hospital. Under Section 1862(a)(9) of the Act (42 U.S.C. § 1395y(a)(9)), payments for custodial care are not covered. Plaintiff has not shown a clear right to the relief requested nor a clear duty of the Secretary to pay the benefits sought, so that mandamus would be an inappropriate remedy.

Judgment affirmed.

(X—refer to SSR–76–39c)

SECTIONS 1861(e) and 1866(b) (42 U.S.C. 1395x(e) and 1395cc(b))—HEALTH INSURANCE BENEFITS—TERMINATION OF PROVIDER OF SERVICES FOR FAILURE TO COMPLY WITH LIFE SAFETY CODE—NECESSITY FOR AN ENVIRONMENTAL IMPACT STATEMENT

20 CFR 405.1022(b) HCFAR–78–39c

Milo Community Hospital vs. *Weinberger*, 525 F.2d 144 (1st. Cir. 1975)

The provider, a 16 bed private nonprofit hospital, was notified that it was to be terminated as a provider of services under Title XVIII of the Social Security Act for failure to comply with the provisions of the 1967 edition of the National Fire Protection Association Life Safety Code. This hospital sought judicial review alleging 1) that the Department of Health, Education, and Welfare had not prepared and issued an Environmental Impact Statement as required by The National Enviromental Policy Act, 42 U.S.C. 4321 *et seq*, and, 2) that the termination was arbitrary, capricious, and a denial of equal protection. *Held*, that no environmental impact statement was required in this case because under the terms of the Medicare Act, the appellant's contentions, that the economic consequences of closing the hospital and the resulting inconvenience and increased use of automobile transportation by Milo residents are environmental consequences that the Secretary had to weigh in reaching his decision to decertify the hospital, are irrelevant to a decertification determination. *Further held*, that the decertification of a small hospital "provider" of services under the Medicare Act for continued noncompliance with significant fire protection provisions of the Life Safety Code is a decision which should be governed by that Act, and a decision which the Secretary has a statutory duty to make when he finds serious noncompliance with fire prevention requirements of the Life Safety Code.

COFFIN, Chief Judge:

The Milo Community Hospital, a sixteen bed private non-profit hospital in Milo, Maine, brought suit in the district court to enjoin defendant Sec-

retary of Health, Education, and Welfare and other relevant officials (HEW) from terminating its federally assisted status as a "provider of services" under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (the Medicare Act). The hospital attacked HEW's decision in two counts of its complaint: in Count One it alleged that HEW had not prepared and issued an Environmental Impact Statement in compliance with the National Environmental Policy Act, 42 U.S.C. § 4321 *et seq.* (NEPA); in Count Two it charged that the termination was arbitrary, capricious, and a denial of equal protection. Jurisdictional grounds asserted were 42 U.S.C. § 4332(2)(C); 5 U.S.C. §§ 702 and 706; and 28 U.S.C. §§ 1331, 1343, and 1361. Defendants denied jurisdiction under both counts and generally admitted the factual allegations. They further answered, as to Count One, that the decertification of a provider under the Medicare Act is controlled by statute and regulation and is not a "major Federal action significantly affecting the quality of the human environment" under NEPA; and, as to Count Two, that the hospital had failed to exhaust its administrative remedies. From a judgment in favor of defendants, entered after hearing by the court, the hospital appeals.

The relevant factual background is the following. Appellant has been authorized to furnish federally compensable Medicare services as a "provider of services", as the term is defined in 42 U.S.C. § 1395x.[1] In October, 1973, the Bureau of Health Insurance of the Social Security Administration (now the Medicare Bureau of the Health Care Financing Administration) notified the hospital of a number of respects in which its facilities failed to comply with the 1967 edition of the National Fire Protection Association's Life Safety Code, the relevant set of standards made applicable by 20 C.F.R. 405.1022(b).[2] After a year of discussion, rectification of some deficiencies, and extensions of time for the hospital to submit an acceptable plan of correction, the Bureau, in November, 1974, issued its formal letter, notifying the hospital that, as of December 13, 1974, its Medicare provider agreement would be terminated. The hopsital was advised that, if the Medicare program requirements were met in the future, it could request re-establishment of its eligibility to participate as a provider. It was further advised of its rights to request and have a hearing

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1 A provider "hospital" under this statute must be an institution which meets, in addition to requirements relating to the nature and scope of professional services, "such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution." 42 U.S.C. § 1395x(e)(9).

2 While some items noticed were relatively minor, others were more basic and pervasive, such as the unprotected wood frame construction, lack of fire-stoppers in concealed spaces, lack of non-combustible interior walls and partitions, and inadequate means of egress.

before an administrative law judge within six months.[3] While the hospital sought, and was denied, reconsideration, it did not seek administrative review of the Bureau's action, but brought this suit.

During the same period, the Bureau had advised two other small hospitals in nearby towns of their failure to comply with the Life Safety Code. One, in Dexter, was terminated as a provider in December, 1974. The other, in Dover-Foxcroft, was allowed, subject to correcting certain deficiencies, to continue as a provider, pending construction of a new regional hospital in the same town—a project in which Dover-Foxcroft and several other communities had voted to participate and for which a firm time schedule had been determined.[4] The town of Milo voted twice not to join the new Hospital Administrative District, the second occasion of such vote being in December, 1974, at which time Milo also voted to appropriate $390,000 for new hospital facilities and to raise $150,000 by a fund drive. As of March 5, 1975, the date of hearing before the district court, no firm plan for construction and financing had been submitted.

The district court found that termination of the hospital's provider status would force it to close, causing Milo patients to travel 13 miles to Dover-Foxcroft or 32 miles to Bangor. In addition to the deprivation of local hospital facilities, the town would lose some $170,000 in annual hospital payroll and $30,000 in annual local purchases. Established by stipulation were the facts that HEW had not filed an Environmental Impact Statement (EIS) and, indeed, that its position has always been that 42 U.S.C. § 4332(2)(C) of the National Environmental Protection Act was not applicable to certification and decertification decisions under the Medicare Act.

[1] The district court held that it had jurisdiction, that—as to Count One—HEW was not required to file an EIS before terminating the hospital's provider status,[5] and—as to Count Two—that the hospital was not entitled to judicial review since administrative remedies had not been exhausted. The court added, although unnecessary to its decision, that it found no merit in the claims of arbitrariness and denial of equal protection.

Since the decision of the district court, the Supreme Court has spoken most relevantly to the jurisdictional issues in the present case. In *Wein-*

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3 Subpart O of Part 405 of the regulations governing federal health insurance for the aged and disabled, §§ 405.1501–405.1595, spell out in elaborate detail the procedures available to a provider of services wishing to contest an initial determination that it no longer qualifies. The various steps include a request for reconsideration, a hearing before an administrative law judge, and a discretionary review by an Appeals Council panel of three persons, one of whom must be from the U.S. Public Health Service.

4 It is the disparate treatment given to Milo and Dover-Foxcroft hospitals that gives rise to the equal protection claim.

5 The hospital sought to broaden the issue beyond HEW's failure to file an EIS, by arguing that HEW had violated 42 U.S.C. §4332(A), (B), and (D) by not pursuing an interdisciplinary approach, developing environmentally focused procedures, and exploring alternative uses of resources in its decision making process. Such contentions were not supported by the complaint or the evidence. At no time, on appeal, did the hospital attempt to invoke 42 U.S.C. § 4333, requiring internal agency review of policy and procedures in the light of NEPA.

berger v. *Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522, 1975, the widow of a deceased wage earner was denied certain insurance benefits because she had been the decedent's wife less than the nine months required by 42 U.S.C. § 416(C) for entitlement to benefits. After seeking and being refused reconsideration, she brought suit in district court, challenging the constitutionality of the statute. The Court held that the first two sentences of 42 U.S.C. § 405(h) "prevent review of decisions of the Secretary save as provided in the Act, which provision is made in § 405(g)." [6] 422 U.S. at 757, 95 S.Ct. at 2463. In this case it would seem irrelevant to analyze each of the heads of jurisdiction alleged by appellant. Some, such as 28 U.S.C. § 1331, are clearly not available. But whether other bases of jurisdiction are present or not, § 405(g) is both a source of jurisdiction and a limitation on its exercise.

Section 405(g) sets forth the procedure to be followed in obtaining judicial review of the Secretary's decision. It commences with the words, "Any individual, after any final decision of the Secretary made after a hearing . . . may obtain a review of such decision by a civil action . . . ." [7] The Supreme Court in *Salfi* variously characterized this requirement as "central to the requisite grant of subject matter jurisdiction", *id.* at 764, 95 S.Ct. at 2466, "a statutorily specified jurisdictional prerequisite", *id* at 766, 95 S.Ct. at 2467, "something more than simply a codification of the judicially developed doctrine of exhaustion", *loc. cit.*, but "not precisely analogous to the more classical jurisdictional requirements . . . as [28 U.S.C.] 1331 and 1332." *Loc. cit.* It is not made inapplicable by reason of a constitutional challenge, beyond the power of the Secretary to take remedial action. The requirement, however, is not jurisdictional in an inflexible sense, as Mr. Justice Brennan noted in dissent, *id.* at 799, 95 S.Ct. 2457, since the Secretary may "determin[e] in particular cases that full exhaustion of internal review procedures is not necessary for a decision to be 'final' within the language of § 405(g)." *Id.* at 767, 95 S.Ct. at 2467.

In *Salfi*, despite a defense of failure to exhaust contained in a motion submitted to the district court, the Court noted that the Secretary was not raising on appeal any challenge to the sufficiency of the allegations of exhaustion in the complaint and interpreted that action to be a "determination by him that for the purposes of this litigation the reconsideration determination is 'final'." *Id.* at 767, 95 S.Ct. at 2468. In the case at bar there is no question but that HEW has consistently raised and argued nonexhaustion as to Count Two both in the district court and before us. The

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6 Section 405(h) is facially applicable to determinations of the Secretary under Title II of the Social Security Act, but by 42 U.S.C. § 1395ii is also made applicable to the present Title XVIII proceeding. So also is § 405(g) made applicable to this case by 42 U.S.C. § 1395ff(c).

7 The fact that the Secretary, not having been so requested, did not hold a hearing does not affect the "finality" of the decision within the meaning of § 405(g). It is clear from the statute, the regulations, and the Court's decision in *Salfi* that, while an aggrieved person or institution has a right to a hearing, the holding of a hearing (which is not requested) is not a predicate to a final decision.

district court was clearly correct in its holding that appellant could not claim judicial review of its due process and equal protection claims.

HEW's stance as to Count One is much less forthright. Although the answer began with a blanket denial of jurisdiction, Count One flatly asserted, by way of a detailed additional answer, the inapplicability of NEPA. This approach was in marked contrast to the answer to Count Two, where a detailed additional answer affirmatively raised the issue of non-exhaustion. In addition, the case was tried to the district court on the theory that it could reach the merits on Count One although not on Count Two. And the court noted the stipulation that it had always been HEW's position that decertification decisions were not subject to NEPA's requirements. It was not until the appeal, subsequent to the decision in *Salfi*, that HEW argued that § 405(g) bars judicial review of all issues in the case.

Understandable though HEW's change of mind might be, having the benefit of the Court's strictures as to the sweep of § 405(g), we cannot avoid the conclusion that, for purposes of the trial below, the Secretary through his counsel, had made a determination that his refusal to reconsider his decision that no Environmental Impact Statement need accompany a decertification action was "final".

We arrive at this conclusion reluctantly. We would prefer not to decide the NEPA issue on the merits but defer decision until a case appears where full administrative review has been had. The deliberations of an administrative law judge and an Appeals Council could not fail to provide both a deeper perspective and more thorough consideration than are permitted a court, which can be concerned only with legal error.

[2] Appellant, however, deliberately refused to follow the course of administrative review and, HEW having effectively determined in this case that exhaustion would not be necessary, we must decide the merits. We decide on as narrow a ground as possible. We need not decide whether an Environmental Impact Statement will ever be required before a decertification decision is made. We do not exclude the possibility that such a decision might have a sufficient environmental impact to constitute a major federal action significantly affecting the quality of the environment, and we decline to consider whether environmental considerations would be irrelevant to all decertification decisions. Here we decide only that the Secretary did not err in failing to prepare an Environmental Impact Statement because, under the circumstances of this case, consideration of the factors that the appellant has characterized as "environmental considerations" could not have changed the Secretary's decision.

Appellant's contention is that the economic consequences of closing the hospital and the resulting inconvenience and increased use of automobile transportation by Milo residents are environmental consequences that the Secretary had to weigh, via an impact statement, in reaching his decision to recertify the hospital. Accepting *arguendo* appellant's characterization of these factors as "environmental considerations", we hold that no impact statement was required because under the terms of the Medicare Act these considerations are irrelevant to a decertification determination. When the Secretary finds serious noncompliance with fire prevention require-

ments of the Life Safety Code, he is under a statutory duty to terminate the Provider Agreement. The kind of dislocation that Milo Hospital alleges it will experience will accompany most termination decisions. We are certain that Congress did not intend the Secretary to have the discretion to give any weight to such consequences in arriving at a termination decision. Not only, therefore, were such factors irrelevant, but they would also be impermissible factors for the Secretary to consider in making this decision. Under these circumstances we hold that no impact statement was required.

Therefore, whether or not the decertification action in this case could be said to be "major", and whether or not the prospective social and economic impact could be said to fall within the statutory term, "quality of the human environment", *see Maryland-National Capital Park and Planning Commission* v. *U.S. Postal Service,* 159 U.S.App.D.C. 158, 487 F.2d 1029 (1973), and *Hanly* v. *Kleindienst,* 471 F.2d 823 (2nd Cir. 1972), we hold that the decertification of a small hospital as a "provider" or services under the Medicare Act for continued non-compliance with significant fire protection provisions of the Life Safety Code is a decision which should be governed solely by that Act.

Affirmed.

(X—refer to SSR–77–9c)

SECTION 1861(v)(1)(A) (42 U.S.C. 1395x(v)(1)(A)) HEALTH INSURANCE BENEFITS—REASONABLE COSTS—EFFECT OF ASSUMPTION OF OPERATING COSTS

20 CFR 405.486(b)(1) HCFAR–78–40c

Vallejo General Hospital v. *Weinberger,* CCH Medicare–Medicaid Guide #28373, (N.D. CA., Feb. 9, 1977)

The hospital leased its radiology department but continued to provide certain maintenance services to the department in return for a fixed percentage of the radiologist's gross billings. Over the period of time in question, rent exceeded the hospital's cost of providing maintenance services. *Held,* that section 405.486(b)(1) of Social Security Regulations No. 5, authorizes the Secretary to reduce the otherwise reimbursable costs of all hospital departments by the Medicare portion of the net lease revenue.

The court recognized that a hospital which leases out its radiology department may receive Medicare reimbursement, channeled through the payments of the radiologist, which includes payments in excess of the hospital's actual costs of serving Medicare beneficiaries. Accordingly, a set-off of the excess revenue against the hospital's otherwise reimbursable Medicare costs insures that only the hospital's reasonable costs of providing services are reimbursed. Further, the court found contrary to the hospital's position that the Secretary must use section 405.486(b)(2) to prevent Medicare payment of a hospital's profit under a lease by restricting the Part B reimbursement to the physician that both section 405.486(b)(1) and section (b)(2) seek the same objective, to limit the reimbursement to its costs of operation.*

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* While we do not acquiesce in that portion of the court's decision finding that the court had jurisdiction under the Administrative Procedure Act, we are publishing the decision as a Ruling because we agree with the court's findings on the merits.

WEIGEL, District Judge:

Plaintiff Vallejo General Hospital brings this action to challenge a determination of the Secretary of Health, Education and Welfare ("the Secretary") reducing the hospital's reimbursement under the Medicare Act, 42 U.S.C. §1395 *et seq.* (1970). Both plaintiff and defendants move for summary judgment. Defendants also move to dismiss for lack of subject matter jurisdiction. The motions have been briefed and argued.

Defendants' motion to dismiss is without merit. This Court has jurisdiction, under the Administrative Procedure Act, 5, USC. §702 (1970), to review a decision of the Secretary regarding payments to a hospital under the Medicare Act. *Hazlewood Chronic & Convalescent Hospital, Inc.* v. *Caspar Weinberger*, 543 F.2d 703 (9th Cir. 1976).

The Medicare Act establishes two separate health insurance programs for the elderly. "Part A" of the Medicare program provides federal payments to hospitals for the reasonable costs of rendering hospital services to eligible individuals. "Part B" is a supplementary, voluntary health insurance program. It pays physicians the reasonable charges of their medical services.

Plaintiff Vallejo General Hospital leased out its radiology department. Plaintiff provided certain maintenance services to the leased department. The radiology department handled its own billing. The lease provided that the hospital receive fifteen percent of the radiologist's gross billings. During the years 1966 through 1972, inclusive, the amount paid as rent exceeded the hospital's costs of providing maintenance services by $204,092.00. Of this amount, $59,770.00 represented the portion equal to the percentage utilization of the hospital's facilities by Medicare patients during the years in question.

In computing plaintiff's Part A Medicare reimbursement for the years 1966 through 1972, inclusive, Blue Cross of Northern California, the representative of the Secretary, relied on 20 C.F.R. §405.486(b)(1) (1975) to reduce reimbursement of the Medicare costs generated by the hospital's other departments by the portion of the radiology department's net lease revenue attributable to Medicare patients, $59,770.00. The Blue Cross Association Medicare Provider Appeals Committee sustained this determination.

Plaintiff contends that the Secretary's reduction of the hospital's otherwise reimbursable Medicare costs by the Medicare portion of the profit from the radiology lease constituted an abuse of discretion and was contrary to law. Plaintiff also contends that, even assuming that §405.486(b)(1) properly authorizes such a reduction, the reduction constituted a retroactive application of the regulation in violation of Fifth Amendment Due Process. Finally, plaintiff contends that the administrative hearing before the Blue Cross Association Medicare Provider Appeals Committee denied plaintiff Due Process of Law.

I.

The Secretary reduced plaintiff's otherwise reimbursable Medicare costs by $59,770.00 based on 20 C.F.R. §405.486(b)(1) (1975). This regulation provides:

> The objective in determining reasonable charges where the physician bills patients directly is the same as that expressed in §405.485(a); to bring about as little change as possible (in the normal case) in the

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compensation the physician receives for his services in the hospital. Where the physician bills the patient directly, costs of operating the hospital department which are borne by the physician [*sic*] will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program; the hospital will receive reimbursement through the hospital insurance program for those costs, if any, which it incurs. Where, however, a hospital initially pays some or all of the operating expenses of a hospital department (c.g., pays the salaries of nonprofessional personnel and purchases supplies and equipment), even though subsequently those items and services for which it pays the operating expenses are furnished for the use of the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimbursable under the hospital insurance program as hospital costs, and are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program.

The parties agree that the issue in this case is the proper reimbursement procedure under Part A of the Medicare program of plaintiff's profit from the lease of its radiology department. The profit arose because the lease payments made by the radiologist to the hospital exceeded the hospital's costs for the radiology department. The Secretary asserts that §405.486 (b)(1) authorizes the set-off applied in this case to insure that plaintiff is reimbursed only for its reasonable costs of providing hospital services to Medicare beneficiaries and not for amounts in excess of these costs. Plaintiff contends that §405.486(b)(1) exists solely to insure that plaintiff is not paid twice for the same operating costs, once by Medicare and again under the radiology lease. In this case, plaintiff did not claim Medicare reimbursement for the costs of the services provided to the radiology department. Hence, plaintiff asserts, double payment is impossible, the regulation inapplicable, and the reduction improper. Plaintiff relies upon *Dr. John T. MacDonald Foundation, Inc.* v. *Mathews*, 534 F.2d 633 (5th Cir. 1976).

The Court begins with the principle that judicial deference normally is given to an administrator's interpretation of the statutory scheme the administrator is authorized to carry out. *Johnson's Professional Nursing Home* v. *Weinberger*, 490 F.2d 841, 844 (5th Cir. 1974). For reasons below elaborated, this Court holds that §405.486(b)(1) authorizes the reduction in Medicare reimbursement applied by the Secretary in this case.

The Court finds that the last sentence of §405.486(b)(1) authorizes the Secretary to reduce the otherwise reimbursable Medicare costs of other hospital departments by the Medicare portion of the net lease revenue. The Court reads "[a]ny payments received by the hospital under such an arrangement" to refer to the Medicare portion of lease payments to the hospital. Only the Medicare portion of such payments are included, since the regulations are designed to avoid placing the burden of Medicare costs upon individuals not covered by Medicare, 42 U.S.C. §1395x(v)(1)(A) (1970); 20 C.F.R. §405.402(a) (1975). "[A]llowable costs of the hospital reimbursable through the hospital insurance program" denotes the reim-

bursable costs of all hospital departments. Had this provision been intended to restrict the prescribed reduction to the allowable costs of the particular department for which the payments are made, as plaintiff contends, the provision would provide for a reduction in the allowable costs of the *department,* and would not direct a reduction in the allowable costs of the *hospital.*[1]

This reading of §405.486(b)(1) is consistent with the Medicare Act. Only the reasonable costs of providing hospital services are to be reimbursed under Part A of the Medicare program. 42 U.S.C. §1395f(b)(1) 1970). The Secretary is authorized to establish regulations to determine the proper reimbursement for a hospital's costs. 42 U.S.C. §1395x(v)(1)(A) (1970). If a hospital operates its radiology department itself and contracts with a radiologist to provide professional services, only the hospital's actual costs attributable to serving Medicare beneficiaries are reimbursed under Part A. The radiologist is reimbursed under Part B for his reasonable charges. However, if a hospital leases its radiology department, the hospital's Medicare reimbursement, channeled through the payments of the radiologist, can include payments in excess of the hospital's actual costs of serving Medicare beneficiaries. A set-off of this excess revenue against the hospital's otherwise reimbursable Medicare costs may be made to insure that only the hospital's reasonable costs of providing services are reimbursed. This construction of §405.486(b)(1) also gives effect to the purpose of the Medicare Act to insure that adequate medical care is available to the aged throughout the country. S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in [1965] *U.S. Code Cong. & Admin. News* 1943, 1964. The set-off authorized by this provision conserves Medicare dollars while fully compensating hospitals for their costs of providing services.

The Court rejects plaintiff's contention that the Secretary may prevent Medicare reimbursement of the hospital's profit under §405.486(b)(2), but may not do so under §405.486(b)(1). *Cf. MacDonald, supra* at 638–39. §405.486(b)(2) provides:

> Where a hospital has been receiving, as its portion of the receipts for such services, significantly more or less than the costs the hospital has incurred in the provision of the services, this excess or shortage should not be transferred from the hospital to the physician merely because he decides to bill his patients directly. Since payment to the hospital is made on the basis of its reasonable costs for all hospital services, the transfer of such excess or shortage to the physician necessarily would alter the total cost of patient hospital and medical care —a result which the legislation was not intended to bring about. *The reasonable charges of a physician who enters into a lease or similar arrangement with a hospital under which the physician assumes the costs of operating the department and bills the patients directly would be based upon the remuneration he received for his services immediately*

1. Offsetting the net revenue from the radiology lease against otherwise reimbursable Medicare costs of other hospital departments, the procedure followed in this case, produces the same result as reducing allowable Medicare costs from all hospital departments by the lease payments of the radiologist.

prior to the leasing arrangement plus his reasonable costs of operation, taking into account the hospital's cost experience in providing such services. Reasonable charges, so determined, would be subject to appropriate future adjustment to take into account changing economic factors. Reference back to the remuneration formerly received by the physician from the hospital as a factor in determining his reasonable charges under the lease or similar arrangement is required to give effect to the provisions of the statute which direct that consideration be given, in determining reasonable charges, to the customary charges generally made by the physician for similar services. Where no pattern of customary charges has been established for the physician's professional services to patients other than the compensation he received from the hospital for his services, such compensation would serve as the basis for establishing the customary charge. (Emphasis supplied.)

Plaintiff asserts the Secretary must use §405.486(b)(2) to prevent Medicare payment of a hospital's profit under a lease by restricting the Part B reimbursement of the physician's lease payments to the physician's "reasonable costs of operation." Even if the Court were to hold that §405.486(b)(2) excludes from the physician's Part B reimbursement that portion of the lease payments in excess of the hospital's actual costs for the leased department, an issue this Court does not decide, this interpretation would not conflict with §405.486(b)(1) since both provisions would seek the same objective, limiting the hospital's reimbursement to its costs of operation. Plaintiff cites no evidence to indicate that §405.486(b)(2) was intended to be the exclusive means by which the Secretary can deal with the problem of Medicare reimbursement in excess of a hospital's actual costs.

The Court also rejects plaintiff's contention that the illegality of the Secretary's interpretation of §405.486(b)(1) is demonstrated by the Secretary's failure to set-off the net revenue from other hospital services, care of private, non-Medicare patients, for example, against otherwise reimbursable Medicare costs. The cost of serving Medicare beneficiaries may not be placed upon individuals not covered by Medicare. 42 U.S.C. §1395x(v)(1)(A) (1970); 20 C.F.R. §405.402(a) (1975). Where net revenue is derived from hospital activities not reimbursable under the Medicare program, the Secretary may not set-off this revenue against otherwise reimbursable Medicare costs.

II.

In the final settlement of plaintiff's Medicare reimbursement for the years 1966 through 1970 the Secretary did not reduce plaintiff's otherwise reimbursable Medicare costs by the Medicare portion of the net revenue from the radiology lease. In 1973, the Secretary reopened the cost determinations for the years 1966 through 1970. For each of the years 1966 through 1972, inclusive, the Secretary made the challenged reduction.

Plaintiff asserts that the application of §405.486(b)(1) to the years 1966 through 1972 when plaintiff had no notice of the regulation's requirements and after the time when plaintiff could have taken remedial action to deal with the regulation's consequences constitutes a retroactive application of the regulation in violation of Fifth Amendment Due Process.

Not every law with retroactive effect is unconstitutional under the Due

Process Clause. "Only when the retroactive effects are so wholly unexpected and disruptive that harsh and oppressive consequences follow, is the constitutional limitation exceeded." *Hazelwood Chronic & Convalescent Hospital, Inc., supra* at 708.

Section 405.486(b)(1) was adopted in 1966. This Court holds in an earlier part of this opinion that, by its terms, §405.486(b)(1) authorizes the reduction applied by the Secretary in this case. This reduction is consistent with the remedial purpose of the Medicare Act. 20 C.F.R. §405.499g (c) (1973) (removed 39 Fed. Reg. 34515 (1974)) placed plaintiff on notice that prior reimbursement decisions could be reconsidered in order to correct a determination inconsistent with applicable regulations.[2] Given these considerations, the Court finds that the application of §405.486(b)(1) to the period 1966 through 1972, inclusive, was not so unexpected, disruptive, harsh, or oppressive as to violate plaintiff's right to Due Process of Law.

III.

Plaintiff's charge of denial of Due Process in its administrative hearing before the Blue Cross Association Medicare Provider Appeals Committee is directed at the alleged biased composition of the Committee and at the Committee's alleged refusal to consider the legality of the challenged regulation. Neither party disputes the underlying facts of this case. The only issue is whether the Secretary's application of §405.486(b)(1) to plaintiff was according to law. Since this Court decides that issue today, plaintiff's Due Process challenge to its administrative hearing is moot.

IV.

IT IS ORDERED that plaintiff's motion for summary judgment is denied. IT IS FURTHER ORDERED that defendants' motion to dismiss for lack of subject matter jurisdiction is denied. IT IS FURTHER ORDERED that defendants' motion for summary judgment is granted and that judgment be entered for defendants.

(X—refer to SSR–77–36c)

SECTION 1861(v)(1)(A) (42 U.S.C. 1395x(v)(1)(A))—HEALTH INSURANCE BENEFITS—REASONABLE COST—EXCLUSION OF CASUALTY LOSSES FROM REIMBURSEMENT

20 CFR 405.415–405.418, and 405.453(f) HCFAR–78–41c

St. Joseph's Hospital v. *Califano*, USDC, D.C., CIV. NO. 76–1558(2/25/77)

The plaintiff, a hospital, suffered severe physical damage as a result of a flood. To replace its lost or destroyed facilities, the hospital applied for funds

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2. 20 C.F.R. §405.499g(c) (1973) provided:
A determination, as specified in paragraph (a) of this section, and a decision, as specified in paragraph (b) of this section, shall be reopened and corrected by an intermediary if, within 3 years of the date specified in paragraph (a) or (b) of this section, as the case may be, the Social Security Administration notifies the intermediary that such determination or such decision is inconsistent with the applicable law, regulations, or general instructions issued by the Social Security Administration in accordance with the Secretary's agreement with the intermediary.

under the Disaster Relief Act of 1970. The application was conditionally approved, and the funds received by the hospital were actually used to rebuild and replace its facilities. It also sought reimbursement for its capital losses under the Medicare program. In accordance with section 1861(v)(1)(A) of the Social Security Act, reimbursement is allowed for actual costs incurred in providing services to Medicare patients. Actual costs include depreciation on capital assets. *Held*, the Secretary did not act arbitrarily or violate the law by determining that the depreciation on the casualty losses (i.e., assets lost in the flood) was not an actual cost of providing Medicare services. Since the hospital was rebuilt with other Federal funds, Medicare money was not needed to insure replacement of vital facilities, particularly where the hospital is now receiving reimbursement for depreciation on its new capital assets.

GESELL, District Judge:

In June, 1972, plaintiff, St. Joseph's Hospital, suffered extensive damage as the result of a flood. To replace its lost or destroyed facilities the Hospital applied for funds under the Disaster Relief Act of 1970 (P.L. 91–606), as amended (1971).* The application was conditionally approved, and the Hospital received over three million dollars with which it has rebuilt and replaced its facilities. It also sought reimbursement for its capital losses under the Medicare Act. 42 U.S.C. § § 1395 *et seq.* Reimbursement was denied and it is this ruling which plaintiff seeks to overturn. 42 U.S.C. §1395 oo(f)(1). This matter comes before the Court on cross-motions for summary judgment. The administrative record was reviewed and full oral argument was heard.

Under the Medicare Act, and regulations promulgated thereunder, hospitals providing services to medicare beneficiaries ("providers") are reimbursed for the necessary costs of such services. Reimbursement is often carried out by private organizations, acting as intermediaries, which have experience with such tasks. *See* 42 U.S.C. §1395(h). To be reimbursed, providers must file cost reports with the intermediaries. 20 CFR 405.453(f). Under these provisions plaintiff included among its 1973 costs $43,185.00 in flood losses.** This amount was disallowed by the intermediary, and by a Provider Reimbursement Review Board. The Review Board decision was not altered by the Secretary of HEW and constitutes final agency action. 42 U.S.C. §1395 oo. Plaintiff claims this denial was arbitrary, capricious and unlawful. *See* 5 U.S.C. §706(2).

The Medicare Act only allows reimbursement for actual costs, as determined by the Secretary of HEW, incurred in providing services to Medicare recipients. 42 U.S.C. §1395x(v)(1)(A). Under the Secretary's regulations actual costs include depreciation expenses on capital assets. 20 CFR §405.416–405.418. This is because it is necessary to provide capital for replacement of facilities after they become unusable, and because the facilities age while providing Medicare services, 20 CFR 405.418(b).

It is admitted that at the time no regulation covered depreciation on casualty losses where federal disaster funds were made available. Never-

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* The Disaster Relief Act was repealed and rewritten by P.L. 93–288 (1974), 42 U.S.C. §5155, but that does not affect this case.

** The loss was reported as a deferred charge. The remainder of the capital asset losses, $1,074,233 would be reported in succeeding years.

theless, the Hospital claims that it is entitled to depreciation on the assets lost in the flood, *i.e.*, its casualty loss. It asserts that this loss is an "actual cost" under the generally accepted accounting principles which HEW requires that it use to keep its books. The Hospital also maintains that in what it perceives to be a similar situation, where hospital facilities are abandoned, providers are entitled to recoup depreciation costs.***

The Secretary did not act arbitrarily or violate the law by determining, in effect, that depreciation on these casualty losses was not an actual cost of providing Medicare service. The lost capital assets obviously were not exhausted in the provision of service to Medicare beneficiaries. Furthermore, since the Hospital was rebuilt with other federal funds, Medicare money was not needed to insure replacement of vital facilities, particularly where the Hospital is now receiving reimbursement for depreciation on its new capital assets. That these losses may be general costs of the Hospital is irrelevant since the statute reimburses only what the Secretary determines are the necessary costs of Medicare services. Nor was it arbitrary for the Secretary to treat this case differently than he does the abandonment of unusable facilities. Where hospital facilities are abandoned, in reality they have been completely consumed during the provision of Medicare services. Further, Medicare money may be necessary to provide new facilities. That is clearly not the case here.

The defendant's motion for summary judgment is granted, plaintiff's motion for summary judgment is denied, and the complaint is dismissed.

SO ORDERED.

***Plaintiff also claimed that another hospital hit by disaster received both disaster funds and Medicare funds. But defendant's contested statement of material facts indicates the Medicare funds were allocated first, and on the record it is impossible to determine the final outcome of that situation. At oral argument counsel indicated the matter was still pending administratively. Thus, it cannot affect the outcome of this litigation.

(X—refer to SSR–77–37c)

SECTION 1878 (42 U.S.C. 1395oo) HEALTH INSURANCE BENEFITS—COMMISSIONER'S REVIEW OF DECISION OF PROVIDER REIMBURSEMENT REVIEW BOARD—BOARD JURISDICTION*

20 CFR 405.1809 and 405.1811 HCFAR–78–42

Where the Provider Reimbursement Review Board (Board) affirmed an Intermediary's adjustment, made as a line adjustment to a Provider's 1973 cost report, reducing program reimbursement to the Provider for costs incurred during its 1970, 1971, 1972, and 1973 cost reporting periods, the Commissioner of Social Security held that Section 243(c) of Public Law 92–603 specifically limits the Board's jurisdiction to accounting periods ending on or after June 30, 1973 and that under 20 CFR 405.1811(a), hearings can be conducted for earlier cost years only by Intermediaries.

ISSUE

The issue before the Commissioner is whether the Provider Reimbursement Review Board may review an Intermediary's adjustments reducing reimbursement to a Provider for costs incurred during cost reporting periods ending before June 30, 1973, where the adjustments were made as a line adjustment to a cost report filed after June 30, 1973.

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

The Provider Reimbursement Review Board affirmed adjustments made by the Intermediary, not only for the Provider's cost year ending August 31, 1973, but also for cost years ending August 31, 1972, August 31, 1971, and August 31, 1970, because "[t]he changes in reimbursement for each year were carried forward as line item adjustments to the settlement page of the August 31, 1973, Medicare cost reports for [the] provider."

LAW, REGULATIONS AND OTHER REFERENCES

The Provider Reimbursement Review Board was established pursuant to the Social Security Amendments of 1972 (P.L. 92–603 §243 enacted October 30, 1972) which added Section 1878 to the Social Security Act (42 U.S.C. 1395oo). Section 243(c) of Public Law 92–603 specifically set forth, the following:

> "The amendments made by this section shall apply with respect to cost reports of providers of services, as defined in Title XVIII of the Social Security Act, *for accounting periods ending on or after June 30, 1973.*" (Emphasis supplied). Section 1878 of the Social Security Act (42 U.S.C. 1395oo) provides,

in pertinent part, as follows:

> "(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by the Provider Reimbursement Board . . . if—

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* Although the source of this ruling is a Commissioner's Decision reviewing a Provider Reimbursement Review Board case, the ruling itself is only an excerpt of that decision and some editorial revision has been made for greater clarity.

(1) such provider—

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report. . . ."

Regulations No. 5 of the Social Security Administration (20 CFR 405.1809 and 20 CFR 405.1811) govern providers' rights to administrative hearings where a disputed determination involves a cost-reporting period ending prior to June 30, 1973.

20 CFR 405.1811 provides that:

"(a) The provider who has been furnished a notice of amount of program reimbursement may request an intermediary hearing if (1) it is dissatisfied with the intermediary's determination contained in such notice and (2) the amount of program reimbursement in controversy is at least $1,000 but less than $10,000 for cost-reporting periods ending on or after June 30, 1973, or for cost-reporting periods ending prior to June 30, 1973, the amount of program reimbursement in controversy is at least $1,000. . . ."

20 CFR 405.1809 sets forth:

"Each intermediary shall establish and maintain written procedures for hearings in accordance with these regulations for resolving any issue which may arise between the intermediary and a provider as to the amount of program reimbursement due the provider or due the health insurance program. These procedures shall provide for a hearing on the intermediary's reasonable cost determination contained in a notice of amount of program reimbursement (see §405.1803) when a timely request for a hearing on this determination is made by the provider to the intermediary and for cost-reporting periods ending prior to June 30, 1973, the amount of program reimbursement in controversy is at least $1,000, or for cost-reporting periods ending on or after June 30, 1973, the amount of program reimbursement in controversy is at least $1,000 but less than $10,000."

EVALUATION

It is the opinion of the Commissioner that the Board has no authority to rule on a provider's accounting period ending before June 30, 1973. The statutory limitation on the Board's jurisdiction to conduct hearings on cost reports only for accounting periods ending on or after June 30, 1973, is precisely expressed in PL 92–603, Section 243(c). The cost report document itself is not controlling to the extent it purports to deal with more than one cost accounting period; it is rather the expenditures, transactions, and activities actually incurred or engaged in by the provider during the individual accounting period (which is reflected on the cost report) which are determinative of jurisdiction. Section 1878(a) of the Act restricts Board hearings to the amount of total program reimbursement due the provider for items and services furnished for the period covered by the report.

Conversely, 20 CFR 405.1809 and 20 CFR 405.1811 explicitly show that a provider has the right to an intermediary hearing where the de-

termination in controversy involves a cost-reporting period ending before June 30, 1973, and the amount at issue is $1,000 or more. The jurisdiction to conduct such a hearing rests exclusively with the intermediary. The statute and regulations define in exact terms the jurisdictional controlling date, applicable to the end of the accounting period, which separates authority to conduct hearings between the Board and an intermediary where the amount in controversy is $10,000 or more.

FINDINGS OF FACT

1. The law establishing the Provider Reimbursement Review Board was enacted in 1972 and gave its applicability as: "for accounting periods ending on or after June 30, 1973."
2. 42 U.S.C. 1395oo specifies Board hearings on determinations of reimbursement due for the period covered by a timely filed cost report.
3. The amount in controversy for the Provider's cost reporting year ending August 31, 1973, exceeds $10,000 exclusive of interest and costs, and its 1973 cost report was timely filed.
4. The Intermediary, upon completion of audits in 1974, computed adjustments reducing reimbursement for the Providers' 1970, 1971, 1972, and 1973 accounting periods.
5. The Intermediary, in effect, applied the reductions for 1970, 1971, 1972, and 1973 to the Provider's Medicare reimbursement for the accounting period ending August 31, 1973.

CONCLUSIONS OF LAW

1. Under PL 92–603, Section 243(c), the Board's jurisdiction is limited to hearing claims for provider reimbursement on cost reports for accounting periods ending on or after June 30, 1973.
2. Pursuant to 20 CFR 405.1809 and 20 CFR 405.1811, jurisdiction to conduct a hearing concerning the issues of program reimbursement for the Provider's accounting periods ending August 31, 1970, 1971, and 1972, rests solely with the Intermediary.

DECISION

The decision of the Board is modified to the extent that the adjustments made by the Intermediary are affirmed only with respect to the cost report for the accounting period ending August 31, 1973.

(X—refer to SSR–77–38)

SECTIONS 1811–1814 and 1878 (42 U.S.C. 1395c–1395w and 1395oo)—HOSPITAL INSURANCE BENEFITS—RECOVERY OF OVERCHARGES—DUE PROCESS

42 CFR 405.480 et seq. HCFAR 78–43c

ST LOUIS UNIVERSITY, et al v. BLUE CROSS HOSPITAL SERVICE, et al, U.S.C.A. 8th Cir (4/12/76) (cert. denied 11/29/76)

A provider sought judicial review of a Provider Appeal Committee decision to limit reimbursement for services of specialist physicians to the pro rata salary paid to those specialists, when they bill through the hospital and their charges are not segregated on patients' bills. The provider claimed, among other things, that because the five member Committee included three employees of the intermediary which made the initial determination, its composition was unfair and improper and thus violated procedural due process. The Court *held* that the composition of the Committee was constitutionally permissible, but *further held* that due process precluded vesting the final determination of issues regarding the proper interpretation of the regulations in the Committee. The Court, therefore, directed that the Secretary adopt and employ appropriate measures to determine the provider's contentions concerning the proper interpretation of the Medicare Act and regulations.

BRIGHT, CIRCUIT JUDGE:

These appeals follow an action brought by St. Louis University challenging certain HEW-mandated procedures and seeking to recover alleged overcharges repaid to HEW by appellant pursuant to an administrative determination by appellees Blue Cross Hospital Service, Inc. of St. Louis and the Blue Cross Association. The dispute arises from services rendered and payments made during appellant's fiscal year ending August 31, 1966, pursuant to the Medicare provisions of the Social Security Act of 1965.[1] In response to cross motions for summary judgment, District Judge John F. Nangle, on February 18, 1975, dismissed counts I and III of the University's complaint but granted relief on count II. The University appealed the dismissal of counts I and III and defendants cross-appealed the judgment on count II.[2]

I. *Background.*

In order to place this case in the proper perspective, the internal organization of St. Louis University must be examined. St. Louis University, as part of its program in the school of medicine; owns and operates a general hospital known as Firmin Desloge Hospital and a psychiatric unit known as the Wohl Institute. These two institutions are known as the St. Louis University Hospitals. The hospitals serve as a teaching and training facility

[1] P.L. 89–97, July 30, 1975, now codified, as amended, as Subchapter XVIII of the Social Security Act, 42 U.S.C. §§1395–1395pp. All statutory citations are to Title 42 unless otherwise indicated.

[2] The complaint contained three counts. Briefly stated, count I alleged violations of applicable statutes and regulations; count II alleged denial of procedural due process; and count III alleged denial of equal protection. For greater detail, *see* p. 6 *infra.*

for the school of medicine and provide medical servces to both Medicare and non-Medicare patients.

Various types of medical care are provided by the hospital. The category of care involved in this case consists primarily of the services of radiologists but also include pathologists, anesthesiologists, and others. Physicians on the staff of St. Louis University who provide these services to hospital patients also perform teaching duties. In compensation for all their medical and teaching services, they receive a salary from St. Louis University.

Prior to the advent of Medicare in 1966, patients of the St. Louis University Hospital received a hospital bill which contained a single charge for this type of medical care. Taking radiology services as an example, that single charge to the patient included two unidentified components: (1) the charge for technicians, equipment, and overhead used in providing x-rays, and (2) the professional charge of the radiologist.

The Medicare program requires that these components be isolated and treated differently. The first component is termed the "provider component" and provides reimbursement for those types of services which normally are furnished by the hospital itself. This charge is covered by part A of the Medicare program. 42 U.S.C. §§1395c–1395i. The second is termed the "professional services component." The professional services component is insured and compensated under part B of the Medicare program. 42 U.S.C. §1395j–1395w. The Medicare Act provides that the amount of reimbursement under part A (provider component) must be determined on the basis of the "reasonable cost" of such services to the provider; under part B (professional services) the basis is the "reasonable charge."

After the enactment of the Medicare Act, the St. Louis University hospitals adopted an internal accounting procedure which segregated the provider and professional services components on the hospitals' books but not on the patient's bill. Despite this new accounting procedure and even though the professional services component was no greater than the admittedly reasonable charges made by physicians in other area hospitals, the University's claim for reimbursement was disallowed to the extent that the professional services component exceeded the actual cost of the service to the hospital based on a pro rata allocation of the salary of the physicians in question. The University was required to refund to HEW all amounts received under part B which exceeded the salary amount.

Not all physicians on the teaching staff of the University hospitals bill patients through the hospitals. Teacher-physicians in certain specialties traditionally have made charges directly to the patient for their services. For example, surgeons bill the patient directly for an operation, notwithstanding that the surgeon is also a salaried member of the University's teaching staff. The surgeon's bill is paid directly to him by the Medicare carrier, and the surgeon turns the payment directly over to the University. In turn, the University pays the surgeon a salary. Where billing is done in this manner, Medicare pays the surgeon's entire bill, provided it is reasonable, even though it exceeds his salary.

In some other hospitals radiologists and related specialists customarily bill the patient directly. In those cases, Medicare pays the full reasonable charge even though it exceeds the radiologist's salary. This also is true even

if the hospital does the actual billing so long as a separate charge for the physician's service (including radiological and similar services) is set out on the patient's bill and provided that this practice was followed prior to the enactment of Medicare. However, if a hospital did not identify a separate professional services component on the patient's bill prior to Medicare, it cannot obtain full reimbursement by now adopting such a procedure.[3]

Some explanation must be made of the system by which disputes with regard to Medicare payments are resolved. The Blue Cross Association (BCA) was nominated by the University Hospitals to serve as their fiscal intermediary with HEW. BCA delegated its duties as intermediary to the Blue Cross Hospital Services, Inc. (the Plan), which is a local Blue Cross group in St. Louis. Part B of the Medicare Act is administered through an insurance carrier under the part B supplemental program. That insurance carrier in this case is General American Life Insurance Company. BCA entered an agreement with the Secretary establishing a five-member Provider Appeal Committee (the Committee). The Committee was to hear appeals by providers who were dissatisfied with the reimbursement allowed by BCA. The agreement required that three of the Committee members be BCA employees—one a BCA vice-president. The other two were appointed by the BCA president from nominees of various national associations of providers. Decisions of the Committee were by majority vote. The agreement specified that decisions of the Committee would be absolutely final.[4]

The University's claim for reimbursement under part B of an amount which its internal bookkeeping identified as the charge for professional services such as those of radiologists, was accepted and paid by the insurance carrier, General American but later, after an audit, was disallowed by the Plan. The Plan has the responsibility for auditing Medicare payments approved by the carrier. The Plan determined that the University's right to reimbursement under part B for services provided by those specialists who bill through the hospital was limited to the pro rata salary paid to those physicians.

The University appealed to the BCA Provider Appeals Committee. The Committee unanimously affirmed the Plan's decision.

When the University lost its appeal before the Committee, it brought this action in district court against BCA, the Plan, and the Secretary of HEW. As we have already noted, *see* note 2 *supra*, the complaint contained three counts. Count I alleged that the Committee's decision violated the Medicare Act and regulations promulgated thereunder. Count II alleged that the makeup of the Committee was unfair and improper and thus violated procedural due process. Count III alleged that essentially identical claims of other providers processed through a different bookkeeping pro-

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[3] In this summary of the facts we describe the regulatory scheme as it has been administratively interpreted in this case, explained in the defendants' briefs, and applied to the University. Our statements here should not be taken as expressing any view of the proper interpretation of the regulations.

[4] The appointment of fiscal intermediaries is authorized by §1395h(a). Providers have the option of not nominating an intermediary and dealing directly with HEW. However, HEW concedes that the use of an intermediary confers significant benefits. Evidently some providers choose to forego these benefits and deal directly with HEW.

cedure had been approved and paid by Blue Cross and HEW, that this distinction was not rationally related to any legitimate governmental objective, and that the University therefore had been arbitrarily and capriciously denied the equal protection of the law.

In ruling on cross-motions for summary judgment, the district court dismissed counts I and III for lack of jurisdiction due to sovereign immunity since those counts sought a money judgment, but granted the University relief on count II for denial of procedural due process. The district court determined that the Committee, consisting as it did of a majority of BCA employees, could not afford an impartial hearing to the University. By way of relief, the district court remanded the University's appeal to the Secretary for a *de novo* evidentiary hearing before a tribunal not containing employees of the BCA. The district court also concluded that the Medicare Act and due process required the Secretary of HEW to review the record of the hearing afforded the plaintiff, citing 42 U.S.C. §1395h(a). We essentially affirm the district court but on different grounds.

II. *Federal Question Jurisdiction Under §1331.*

In examining our federal question jurisdiction alleged by appellant under §1331, we are met with the provisions of 42 U.S.C. §405(h). This section is part of the Social Security Act, but is incorporated "to the same extent as they are applicable" into the Medicare Act by 42 U.S.C. §1395ii. Section 405(h) provides:

> [1] The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. [2] No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. [3] No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 [§1331] of Title 28 to recover on any claim arising under this subchapter.

The Supreme Court in *Weinberger v. Salfi*, 422 U.S. 749 (1975), discussed the jurisdictional bar imposed by this statute to parties who challenged on constitutional grounds those provisions of the Social Security Act which require that the relationship between a wage earner and his wife or step-children must have existed for a fixed time prior to his death as a condition for receiving benefits. The Court reached the merits only with respect to those named individual plaintiffs who had satisfied the requirements of §405(g) which authorizes judicial review. It dismissed the class action for want of Federal question jurisdiction, noting that no allegation was made that class members had exhausted their administrative remedies as required by §405(g). *Id.* at 764.[5]

In the course of its decision, the Court specifically examined §405(h). The Court focused on the third sentence of §405(h) which forbids any

[5] The University urges that §405(g) was incorporated by §1395ii. However §1395ii lists those specific subsections of §405 which it intends to incorporate and §405(g) is conspicuously omitted. Further, such a finding would render superfluous §1395ff(b) which authorizes some limited review and which partially incorporates §405(g). *See* p. 11 *infra.*

action "against the United States, the Secretary, or any officer and employee action for want of federal question jurisdiction, noting that no allegation thereof" brought under §41 [now §1331] of Title 28 "to recover on any claim arising under this subchapter." The Court rejected the view expressed by many federal courts that §405(h) merely required exhaustion of administrative remedies.[6] The *Salfi* Court said:

> That the third sentence of §405(h) is more than a codified requirement of administrative exhaustion is plain from its own language, which is sweeping and direct and which states that *no* action shall be brought under §1331, not merely that those actions shall be brought in which administrative remedies have been exhausted. Moreover, if the third sentence is construed to be nothing more than a requirement of administrative exhaustion, it would be superfluous. This is because the first two sentences of §405(h) * * * assure that administrative exhaustion will be required. [*Id.* at 757 (emphasis in original) (footnote omitted).]

Appellees in *Salfi* argued that they did not seek to "recover on any claim" under the Social Security Act but rather sought to recover under the Constitution. The Supreme Court conceded this argument had some substance, *id.* at 760–62, noting *Johnson v. Robison*, 415 U.S. 361 (1974). However, the Court said that it was "Social Security benefits which appellees seek to recover," *id.* at 760, and that

> [t]o contend that such an action does not arise under the Act whose benefits are sought is to ignore both the language and the substance of the complaint and judgment. [*Id.* at 761.]

Hence, the claims of the class were held to be barred by §405(h) since, due to failure to exhaust administrative remedies, review under §405(g) was improper. The Court said that the reach of §405(h)

> extends to any "action" seeking "to recover on any [Social Security] claim"—irrespective of whether resort to judicial process is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions. [422 U.S. at 762.]

The considerations which led Congress to limit review under the Social Security Act apply with equal force to the Medicare program.

The Medicare statute is a complicated one. Judicial review of the amount of all Medicare payments would bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services—based on facts which vary from community to community. These charges are subject to extensive and complicated statutory guidelines and regulations. *See, e.g.*, 42 U.S.C. §§1395ff, 1395p, 1395u; 20 C.F.R. §405 *et seq.* (Now codified in 42 C.F.R. Part 405) Determining the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.

Section 405(h) should be read with these complications in mind. We think *Salfi* requires us to follow it literally. The Supreme Court's approach

[6] *See, e.g.*, cases cited at note 7 *infra*.

to §405(h) in *Salfi* varies subtantially from the approach taken by those cases which have found jurisdiction. The citation of *Cappadora v. Celebrezze*, 356 F.2d 1 (2d Cir. 1966), in Justice Brennan's dissenting opinion demonstrates that the reasoning of those cases was considered by the Court and bolsters our conclusion that they are inconsistent with the *Salfi* decision.[7] Accordingly, we reject the authority of those pre-*Salfi* cases relied upon by the University.[8] Since count I sought to obtain payments pursuant to the Medicare Act, §405(h) precludes the federal courts from assuming jurisdiction under §1331. Count III seeks similar relief and also would appear to be barred. However, it purports to raise a constitutional equal protection claim. We discuss this aspect of count III in a subsequent portion of this opinion.

III. *Jurisdiction Under the APA.*

The University asserts that jurisdiction is established independently of §1331 by the Administrative Procedure Act, 5 U.S.C. §§702–06. While there is some doubt whether the APA in and of itself affords an indipendent basis for federal court jurisdiction, in this particular case §702 of the APA would preclude finding jurisdiction in any event. The APA provides that if agency action is "committed" to the discretion of the administrator, it is not subject to judicial review under the APA.[9] *See generally Greater New York Hospital Association v. Matthews*, ...F. Supp....., 44 U.S.L.W. 2337 (S.D. N.Y., Dec. 11, 1975).

To determine whether Congress intended to commit the issues raised by the University to agency discretion we must carefully examine the Medicare Act. The provision governing the availability of judicial review in this case appeared in the original Medicare Act. It provided for judicial review on behalf of an individual of

> [a]ny determination [by the Secretary] ** * as to entitlement under Part A or Part B or as to amount of benefits under Part A * * * [42 U.S.C. §1395ff(b) (1970).]

The conspicuous omission of any provision for judicial review of the *amount* of benefits under part B indicates that Congress felt that determi-

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[7] *See id.* at 787 n.2 (Brennan, J., dissenting). Plaintiffs also placed heavy reliance upon *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (3d Cir. 1973), and *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971). These are direct offspring of the *Cappadora* decision. *Rothman v. Hospital Service*, 510 F.2d 956 (9th Cir. 1975), also relies heavily on the *Cappadora* line of cases. The Fifth Circuit appears to have simply assumed jurisdiction. *Mount Sinai Hosp. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, ——U.S.——( )

[8] We are aware that Congress has amended the Medicare Act to create a Provider Reimbursement Review Board whose decisions specifically are made judicially reviewable under the APA. 42 U.S.C. §1395oo (1970) (Supp. III). This does not alter our view of the prior legislative intent. The amendment is applicable only to accounting periods ending on or after June 30, 1973.

[9] 5 U.S.C. §702. Of course, §706(2)(A) authorizes a reviewing court to remedy an "abuse of discretion." Thus, all agency discretion is not insulated from judicial review. The crucial question in each case is whether the matter is sufficiently *committed* to agency discretion as to preclude review. *See* Davis, Administrative Law Treatise §28.16 at 80–81, and 1970 Supplement §28.16 at 964–65.

nation of the proper "reasonable charge" was a matter best left to agency expertise. *Cf. Schillings v. Rogers*, 363 U.S. 666, 674 (1960).

Our view is strengthened by the emphatic language of §405(h) which forbids bringing "any claim under §41 of Title 28." The Supreme Court observed in *Salfi* that at the time §405(h) was adopted

> prior to the 1948 recodification of Title 28, §41 contained all of that title's grants of jurisdiction to United States district courts, save for several [irrelevant] special purpose * * * grants * * *. [422 U.S. at 756 n.3.]

Thus, by precluding any resort to §41, §405(h) completely eliminated all then existing jurisdictional bases for judicial review. This demonstrates a congressional intent to commit maximum discretion to the Secretary.

The University asserts that whatever the Secretary's discretion within statutory confines, he has so far exceeded the statute as to compel judicial intervention. We therefore turn to the statute and implementing regulations. Section 1395*l* of Title 42 authorizes reimbursement in full of the "reasonable charges" for compensable part B professional services. The implementing HEW regulations appear at 20 C.F.R. §405.480 *et seq.* (Now codified in 42 C.F.R. §405.480) They are amplified in detail in §3906.2 and §3906.3 of part A, Intermediary Manual. Section 3906.2 states in part:

> Where provider has customarily identified a physician's charges separately from charges for provider services, the physician's charges so established will be considered the customery charges for his professional services, and will afford the basis for determining the reasonable charges for such services.

In contrast, §3906.3 states in part:

> Where, under an existing arrangement between a provider and physician, billings to patients have not separately identified charges of physician's services and charges for provider services a schedule charge will need to be developed based on the physician's professional component.

The Committee read these two regulations together and reached this conclusion:

> These two sections, then, reiterate the two alternatives available. In effect, either the provider or physician has established the charge or they have not established a separate charge for the physician's services. If they have, that charge is the basis for Part B reimbursement for physician's services; if they have not, a charge is developed (for Medicare reimbursement purposes) based upon the physician's compensation attributable to patient care services. A separate charge has been established when the billings by the hospital have shown a separate charge for the physician's service. This charge must be separated on all billings to patients and third party payors. Only by billing all patients this separate charge can it be established as a charge for that particular service.

The University reads these regulations as interpreted by the Committee as a flat rejection of the mandatory statutory standard of "reasonable charges." HEW, on the other hand, asserts that these regulations do not reject the statutory standard but merely define it. Obviously, there are limits to an

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agency's definitional leeway.[10] However, we cannot say that it is clearly unreasonable to conclude that a physician's reasonable charge for his services is to be determined by his salary. Therefore, it does not appear that the Secretary has so far exceeded statutory parameters as to remove his actions from the purview of §405(h).

IV. *Jurisdiction to Require Procedural Due Process (Count II).*

However, even though we conclude that Congress intended to commit the determination of the proper amount of reimbursement wholly to administrative discretion, we must still face the University's claim under count II that Congress did not and could not approve the administrative process employed in this case. The University points out that HEW subjected it to the bureaucratic whim of a nongovernmental Provider Appeals Committee, a majority of the members of which were officers or employees of BCA whose initial decision was being appealed, and who had an institutional interest in the outcome.[11] According to HEW's view, the Committee's discretion is essentially unrestrained. Judicial review is barred by §405(h) and administrative review is precluded by the agreement between HEW and BCA which established the Committee. HEW will not review the Committee's decision even when a provider asserts that the Committee has blatantly ignored governing statutes, regulations, and constitutional requirements.

The Supreme Court has recognized that totally precluding judicial consideration of constitutional issues raises serious constitutional problems. *Weinberger v. Salfi, supra,* 422 U.S. at 762; *Johnson v. Robison,* 415 U.S. 361, 366 & n.8 (1974). Those constitutional problems are greatly intensified when an agency purports to subdelegate its immunity from judicial review to a nongovernmental entity. It is a "cardinal principle" that we are to ascertain whether a construction of the statute involved is "fairly possible" by which such constitutional doubts may be avoided. *Johnson v. Robinson, supra,* 415 U.S. at 366–67. We are to proceed in what Justice Stewart termed "the candid service of avoiding a serious constitutional doubt."

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[10] The limits of the right to define have never been exactly determined. Early sources indicate that the question is not new. Consider, for example, the following dialogue:

> "When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean—neither more or less."
>
> "The question is," said Alice, "whether you *can* make words mean so many different things."
>
> "The question is," said Humpty Dumpty, "which is to be master—that's all. * * * They've a temper, some of them—particularly verbs, they're the proudest—adjectives you can do anything with, but not verbs—however, *I* can manage the whole lot of them! Impenetrabiltiy! That's what *I* say!"
>
> "Would you tell me, please," said Alice, "What that means?" [L. Carroll, *Through the Looking Glass,* Ch. 6 (emphasis in original).]

[11] The intangible effect of institutional loyalty must not be underestimated simply because it is difficult to quantify. *See* H. Simon, Administrative Behavior 13–14 (1957), *quoted in* W. Gellhorn & C. Byse, Administrative Law: Cases & Comments 891 (5th Ed. 1970). As Justice Jackson commented, "Men are more often bribed by their loyalties and ambitions than by money." *United States v. Wunderlich,* 342 U.S. 98, 103 (1951). *See also Goldberg v. Kelly,* 397 U.S. 254, 271 (1970).

United States v. Vuitch, 402 U.S. 62, 97 (1971) (Stewart, J., dissenting in part).

Thus, we must now return to §405(h) to determine if it precludes our jurisdiction to entertain a due process challenge to the procedures adopted by the Secretary to determine Medicare reimbursements. Section 405(h) forbids any action under §1331 "to recover on any claim arising under this subchapter." Appellees in *Salfi* argued that this did not bar their constitutional claims since they "arose under" the Constitution and not under the Social Security Act. The Supreme Court recognized that this argument had substance. 422 U.S. at 760. However, it rejected the argument because

> not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions. [*Id.* at 760–61.]

The Court also indicated that its decision was influenced by the availability of fully adequate judicial review under §405(g). The Court said:

> In the present case * * * the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. *Thus* the plain words of §405(h) do not preclude constitutional challenges. [*Id.* at 762 (emphasis added).]

In the present case, the due process claim has as its primary goal obtaining a constitutionally adequate hearing. Allowing such a hearing will not necessarily affect the University's entitlement to reimbursement or the amount allowed. Secondly, and more importantly, the Medicare Act does not provide the University an adequate alternative means of obtaining judicial review of its due process claim.

We believe that on these two grounds alone, this case is distinguishable from *Salfi*, and thus §405(h) does not preclude our jurisdiction of count II.[12] However, there is a third basis for distinction. Section 405(h) is incorporated into the Medicare Act only "as * * * applicable." §1395ii. The general rule is that a statute incorporated into another "as applicable" will be read in such a manner "as will give form and effect to the statute into which it is incorporated." *Penrose v. Whiteacre*, 147 P.2d 887, 889 (Nev. 1944), and authority cited therein. If §405(h) were read to wholly preclude adjudication of the University's due process claim it would raise serious constitutional problems which might impair the force and effect of the Medicare Act. Therefore, we find that Congress did not intend for §405(h) to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process.

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[12] The Supreme Court has recently found jurisdiction to review a Social Security beneficiary's claim of a denial of due process. *Mathews v. Eldridge*, ——U.S.——, 44 U.S.L.W. 4224 (U.S. Feb. 24, 1976). The Court emphasized that the due process claim was "collateral to his substantive claim of entitlement" and that no other fully effective review was available *Id.* at——.

On the merits of count II, the district court made the following finding:

> Three of the five Board members who conducted the subject hearing, Chairman Green, Hankle, and Moeller, were BCA employees. BCA had advised the Plan in 1969 on the merits of plaintiff's position and was supportive of the Plan's ultimate decision. Furthermore, BCA was cocontractor with the Plan in providing the intermediary services to plaintiff and the Secretary. The conclusion is inescapable that plaintiff was not afforded a hearing before an impartial decision maker.

The court also found that "both the Medicare Act, 42 U.S.C. §1395h(a) (1965), and the constraints of due process require that the Secretary review the record of any hearing afforded plaintiff." As a remedy the court remanded the case to the Secretary "for a *de novo* evidentiary hearing before a tribunal that does not contain employees of BCA."

While we appreciate the district court's concern over the BCA personnel serving on the Committee, we find that the makeup of the Committee was constitutionally permissible. *See Winthrow v. Larking*, 421 U.S. 35 (1975). Moreover, all parties to this appeal seem agreed that the facts are undisputed. Thus we cannot see that the Committee's factfinding function prejudiced the University in any way.

However, the parties do dispute the proper interpretation of the HEW regulations and whether these regulations are consistent with the Medicare Act. We agree with the district court that due process precluded vesting the final determination of these issues in the Committee as constituted and we doubt that Congress authorized any such delegation of power.[13]

Thus, we modify the judgment of the district court by eliminating the requirement that the Secretary hold a *de novo* evidentiary hearing. While on remand the Secretary may hold such an evidentiary hearing if it is thought desirable, we direct only that the Secretary adopt and employ appropriate measures to determine the University's contentions concerning the proper interpretation of the Medicare Act and regulations.

V. *Jurisdiction to Require Equal Protection (Count III).*

Finally, we must consider count III in which the University advances an equal protection claim. The University asserts that the Committee acted arbitrarily and capriciously by disallowing its claim while allowing identical claims of other providers similarly situated who merely happen to have a different bookkeeping system.

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[13] Section 1395(a) authorizes the Secretary to enter into an agreement with [a fiscal intermediary like BCA] providing for the determination by such agency or organization (*subject* to the provisions of section 1878 [42 U.S.C. §1395oo] and to *such review by the Secretary as may be provided for by the agreement*) of the amount of the payments required * * *. (Emphasis supplied).

HEW reads the language included in parenthesis to allow the Secretary to enter an agreement which precludes any administrative review whatsoever of a fiscal intermediary's determination. However, this takes the parenthetical too far. The statute may well permit an agreement authorizing a properly constituted intermediary to make final factual determinations. However, the general scheme of the statute requires that the Secretary retain sufficient powers of review to assure that fiscal intermediaries comply with HEW regulations and the Medicare Act.

On its face this appears to raise a constitutional issue.[14] The Due Process Clause of the fifth amendment has been held to embody a guaranty of equal protection by the federal government. *See United States Dept. of Agriculture v. Moreno,* 413 U.S. 528, 533 n.5 (1973). Traditionally, equal protection analysis has required that a governmental classification be "rationally related to a legitimatie governmental objective." *Id.* at 533.

Much of our jurisdictional analysis of the procedural due process issue presented in count II would seem to support our jurisdiction of count III, which also arises under the due process guaranty of the fifth amendment. If §405(h) bars our jurisdiction, the University will have no judicial forum in which to assert its constitutional right to equal protection.

On the other hand, the direct purpose of this claim is to increase the amount of reimbursement to the University. Thus, it appears to fall squarely within the language of §405(h) and of the Supreme Court in *Salfi.* 422 U.S. at 760–62. Additionally, count III seeks a money judgment against the United States. The doctrine of sovereign immunity probably would permit the Congress to forbid such an action even if based upon a constitutional violation. *See Dugan v. Rank,* 372 U.S. 609, 620 (1963); *cf Edelman v. Jordan,* 415 U.S. 651 (1974).

We need not reach this difficult issue at this time. Pursuant to count II, we have determined that this case should be remanded to the Secretary for his consideration of the University's position. Consideration of the issues raised in count III must await the Secretary's hearing and decision on the University's claim.[15]

Postponing a decision on count III offers several advantages. In count I, the University has argued that under the proper interpretation of HEW's regulations, it is entitled to full reimbursement. The Secretary may agree. If so, a judicial resolution of the difficult issues presented by count III will be unnecessary. On the other hand, if the Secretary rejects the University's claim, the count III jurisictional issue will be squarely presented. Should jurisdiction be found, judicial assessment of the merits of the claim will be made substantially easier by the Secretary's authoritative construction of the regulations and articulation of their underlying rationale.

Therefore, we make the following disposition of this appeal:

1) The district court's dismissal of count I for lack of jurisdiction is affirmed for the reasons discussed above;

2) The district court's judgment granting relief on count II is modified by eliminating the requirement of a *de novo* evidentiary hearing before a tribunal that does not include members of BCA, but is affirmed to the extent that it requires the Secretary to make a final administrative determination of the medical fee dispute between appellant and appellees.

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[14] The University's complaint in this case is at least somewhat more specific than the conclusory allegations in *Schilling v. Rogers,* 363 U.S. 666 (1960), that the administrative action was "arbitrary and capricious."

[15] As noted in our discussion of count II, the extent of Congress' power to preclude judicial consideration of constitutional issues is itself a difficult constitutional question which has never been clearly resolved by the Supreme Court. It is the settled federal practice to postpone resolving such constitutional issues until a decision is necessary. *Sullivan v. Meade County School Dist.* 101,——F.2d——, 44 U.S.L.W. 2424 (8th Cir., Feb. 26, 1976).

3) The district court's dismissal of count III is affirmed on the ground that it is premature but without prejudice to a later action raising the equal protection clause.

(In an essentially identical case decided by the same court at the same time (Faith Hospital Association, etc. Appellee—Appellant, v. Blue Cross Hospital Service, etc., et al., Appellants—Appellees), the court ruled on a question that did not arise in the St. Louis University litigation. The court affirmed the district court's rejection of the hospital's allegation that the administrative recoupment of alleged overpayments after a lapse of more than 3 years is time-barred by the statute of limitations contained in the Medicare Act. The court further said that "Moreover, we deem the challenged recovery of a Medicare overpayment by the Secretary, assuming such existed in this case, was not against equity and good conscience. We reject the argument made by appellant that since any overpayment to Faith Hospital resulted from the error of an insurance company fiscal intermediary, in this case the Blue Cross Plan of St. Louis, the equities lie with Faith Hospital, again assuming that the hospital actually received an overpayment of Medicare funds.) [Ed.]

SECTION 1812(a), 1861(i) and (j), 1814(a) and 1866(a)(42 U.S.C. 1395d(a), 1395f(a), 1395x(i) and (j), and 1395(cc)—HEALTH INSURANCE BENEFITS—POST HOSPITAL EXTENDED CARE SERVICES—NONPARTICIPATING PROVIDER

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The claimant was timely transferred from a participating hospital to a non-participating skilled nursing facility, which allegedly met all the requirements a skilled nursing facility must meet to qualify for participation in the Medicare program. *Held*, the post-hospital services rendered are not reimbursable in accordance with 42 CFR 405.150, since the institution had not entered into an agreement with the Secretary of Health, Education, and Welfare to participate in the Medicare Program.

The claimant was admitted to a general hospital on June 11, 1973, where she remained until June 27, 1973. "Inpatient hospital services" were provided by this hospital which was participating in the Medicare program and reimbursement was made for the acute care.

On June 27, 1973, when the patient was considered ready for something less than acute care, she was transferred to the XTC nursing facility, a "long-term nursing care facility." It allegedly met the same standards regarding patient care, safety, etc. that a skilled nursing facility must meet to be a provider of extended care services under the Medicare program but was not a participating provider of services in that program.

Section 1812(a) of the Social Security Act provides, in part, that payments may be made (subject to other provisions of the act) for up to 100 days of post-hospital extended care services during any spell of illness. Payment for such extended care services may only be made to skilled nursing facility which has entered into a provider agreement with the Secretary of Health, Education, and Welfare (sections 1814(a) and 1866(a)).

It is clear from the foregoing that lawful payment for post-hospital extended care services may only be made to the skilled nursing facility which provided these services and then only (subject to other limitations) if that facility has an effective agreement, during the period the services were rendered, to participate in the Medicare program as a provider of extended care services. The XTC nursing facility did not have such an agreement and was not a participating provider of such services under the Medicare program.

The claimant contended that consideration should be given to the exceptional circumstances in her case, the intent of Congress, and her reliance on misinformation from representatives of the hospital who informed her that the XTC nursing facility did participate in the Medicare program; later she learned otherwise.

The Social Security Act and Regulations impose a clear and unambiguous requirement which is simply not met in this case. Although it is sympathetic to the claimant's arguments and with the position in which she

found herself, the Health Care Financing Administration has no jurisdiction or authority to grant relief which the law does not authorize.

CUMULATIVE LISTINGS OF SELECTED COURT DECISIONS PUBLISHED AS RULINGS (1967-1977)

75–D7—Depreciation; Change of ownership; Sale of stock v. Sale of assets. (10/17/75)

75–D8—Depreciation; Change of ownership; Sale of stock v. Sale of assets. (10/17/75)

75–D18—Depreciation; Demolition costs; Allocation of demolition costs. (2/9/76)

75–D24—Depreciation; Change from optional allowance in lieu of depreciation to actual depreciation; Demolition costs; Allocation of demolition costs. (2/5/76)

76–D1—Jurisdiction of the Provider Reimbursement Review Board. (2/27/76)

76–D6—Remuneration of hospital-based physicians; Allowance for bad debts. (4/26/76)

76–D11—Related organizations; Interest expense. (5/28/76)

76–D15—Special care units; Treatment of provider rehabilitative unit as special care unit.

76–D17—Related organization; Inclusion of lease and management agreements in allowable costs. (6/23/76)

76–D18—Depreciation; Appraisals: Allocation of sale price to assets sold. (7/13/76)

76–D19—Related organizations; Inclusion of lease and management agreements in allowable costs. (7/6/76)

76–D22—Cost of educational activities: Joint educational activities. (8/3/76)

76–D28—Time requirements for submission of comments to the Commissioner. (8/20/76)

76–D33—Depreciation; Disposal of assets; Gain or loss on disposal of assets; Abandonment of building and equipment. (8/30/76)

76–D42—Cost of educational activities; Joint educational activities; Related organizations. (9/29/76)

76–D44—Depreciation: Loss on sale of assets when optional allowance utilized; Loss on sale of nondepreciable assets. (10/15/76)

76–D45—Depreciation; Recapture of accelerated depreciation. (10/12/76)

76–D49—Depreciation; Recapture of accelerated depreciation. (11/1/76)

76–D53—Depreciation; Recapture of accelerated depreciation. (11/15/76)

76–D59—Interest expense. (11/17/76)

76–D66—Cost of educational activities (1/12/77)

76–D73—Accrued sick pay. (1/31/77)

76–D79—Interest expense; unrestrict gifts. (2/28/77)

76–D80—Cost paid to physician to obtain release from further legal action. (2/22/77)

76–D81—Unrecovered cost to patients of pathologist. (2/22/77)

Numeric Index of Decisions Rendered by the Administrator of Health Care Financing Administration* on PRRB Decisions

77–D6—Cost of educational activities. (3/14/77)

77–D7—Cost of educational activities; joint educational activities; liability insurance. (3/14/77)

77–D10—Interest Expense; Funded Depreciation; Utilization for liquidation of mortgage debt; payments in excess of contractual obligation to provider-based physicians. (4/6/77)

77–D16—Rejection of comments submitted untimely. (5/12/77)

77–D17—Depreciation, goodwill and return on equity capital; Change of ownership; Purchase of capital stock v. purchase of assets; Liquidation of acquired corporation; Accelerated method of depreciation; Group appeals. (5/12/77)

77–D18—Leasing of hospital operating department to physicians; Offset of rental income to allowable costs. (5/20/77)

77–D19—Leasing of hospital operating department to physicians; Offset of rental income to allowable costs. (5/20/77)

77–D20—Leasing of hospital operating department to physicians; Offset of rental income to allowable costs. (5/20/77)

77–D26—Lower of reasonable costs or customary charges; Determination of customary charges. (6/16/77)

77–D31—Rejection of comments submitted untimely. (6/24/77)

77–D32—Lack of substantial evidence in PRRB decision; Credibility of witnesses. (7/1/77)

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* The reorganization of HEW, effective 3/8/77, transferred responsibilities related to administration of Medicare to the Health Care Financing Administration.

77–D38—Depreciation; Disposition of assets; Computation of gain or loss on sale to a nonprovider of asset partially financed by Hill-Burton funds. (8/7/77)

77–D39—Depreciation; Recapture of accelerated depreciation. (8/8/77)

77–D40—Construction interest expense, capitalizing v. expensing; Interest income on funded depreciation not offset against interest expense. (8/9/77)

77–D41—Lower of reasonable costs or customary charges. (8/9/77)

77–D43—Reimbursement for costs of abandoned architectural plans. (8/9/77)

77–D47—Rejection of comments submitted untimely. (9/3/77)

77–D50—Cost related to patient care; Counting of labor and delivery room patients in computing routine patient care costs. (9/12/77)

77–D51—Depreciation; Disposal of assets—abandonment of hospital; Donation of hospital; cost related to patient care; gain or loss on disposal of hospital; change from optional allowance in lieu of depreciation to actual depreciation. (9/23/77)

77–D60—Depreciation allowance; Cost basis for depreciation of facility as an ongoing operation. (11/4/77)

77–D61—Change of ownership; Franchise taxes based on income disallowed; Reasonable cost related to patient care; Return on equity capital; Related organizations exception; Sale of stock v. sale of assets; Goodwill; Interest costs; PRRB jurisdiction; Revaluation of assets for depreciation; Stock maintenance costs. (11/4/77)

77–D62—Rejection of comments submitted untimely. (10/28/77)

77–D65—Depreciation; Recapture of accelerated depreciation; Useful life of assets; Disposal of assets; Lower of reasonable cost or customary charges; Excludable costs; Nonvested sick leave. (11/25/77)

77–D68—Labor/delivery room; customary charges. (11/25/77)

77–D69—Joint educational activities; Liability insurance. (11/28/77)

77–D71—Joint educational activities. (12/16/77)

77–D75—Purchase of stock v. purchase of assets; Interest costs; Related organizations; Sale of stock v. sale of assets; Revaluation of assets for depreciation; Return on equity capital. (12/16/77)

77–D76—Definitive observation units/Intermediate care units. (12/27/77)

77–D77—Related organizations; Sale of stock v. sale of assets; Revaluation of assets for depreciation; Return on equity capital.

77–D83—Definitive observation units/Intermediate care units; Fraud losses; Excess of theft loss over insurance coverage allowable. (1/10/78)

77–D84—Interest expenses; Related organizations. (1/17/78)

77–D85—Purchase of stock v. purchase of assets; Return on equity capital; Revaluation of assets for depreciation. (1/12/78)

77–D88—Joint educational activities. (1/31/78)

77–D89—Purchase of stock v. purchase of assets; Revaluation of assets for depreciation; Stock maintenance costs; Related organizations; Reasonable costs related to patient care; Return on equity capital. (1/31/78)

77–D91—Labor/delivery room; Customary charges. (2/2/78)

77–D92—Lower of reasonable costs or customary charges; Determination of customary charges. (2/6/78)

77–D94—Reasonable costs; Necessary and proper; Salaries of directors (2/16/78)

77–D95—Lower of reasonable costs or customary charges; Determination of customary charges. (2/12/78)

77–D96—Purchase of stock v. purchase of assets; Interest costs; Return on equity capital; Revaluation of assets for depreciation. (2/17/78)

78–D2—Collection agencys' fees. (3/20/78)

78–D3—Depreciation; Recapture of accelerated depreciation; Return on equity capital. (3/20/78)

78–D5—Depreciation; Disposal of assets; Recapture of accelerated depreciation; Unemployment compensation costs; Pension costs; Lower of reasonable cost or customary charges. (3/24/78)

Quarterly Listings of Published Health Care Financing Administration Program Regulations (Jan.-March 1978)

The following amendments and additions to HCFA regulations have been published in the *Federal Register*:

1. 42 CFR Part 478—Advisory Groups to Statewide Professional Review Councils (January 4, 1978—43 FR 854)
2. Notice—Pharmaceutical Reimbursement Advisory Committee—Request for Nomination of Members (January 13, 1978—43 FR 2004)
3. 42 CFR Part 476—Confidentiality and Disclosure of Information by Professional Standards Review Organizations (January 16, 1978—43 FR 2282)
4. Notice—Physicians in Arizona—Designation of Professional Standards Review Organization for PSRO Area II (January 16, 1978—43 FR 2228)
5. Notice—Physicians in North Carolina—Designation of Professional Standards Review Organization for PSRO Area VII (January 16, 1978—43 FR 2228)
6. Notice—Physicians in Ohio—Designation of Professional Standards Review Organization for PSRO Area IV (January 16, 1978—43 FR 2228)
7. Notice—Physicians in Pennsylvania—Designation of Professional Standards Review Organization for PSRO Area V (January 16, 1978—43 FR 2228)
8. Notice—Physicians in Virginia—Designation of Professional Standards Review Organization for PSRO Area I (January 16, 1978—43 FR 2229)
9. 42 CFR Part 460—Professional Standards Review Organization Area Designations (January 18, 1978—43 FR 2630)
10. Notice—Pharmaceutical Reimbursement Advisory Committee—Charter Renewal (January 19, 1978—43 FR 2760)
11. 42 CFR Part 450—Administration of Medical Assistance Programs—State Medicaid Fraud Control Units (January 23, 1978—43 FR 3118)
12. Notice—HCFA Rulings—Publication (January 30, 1978—43 FR 3944)
13. Notice—Michigan Statewide Professional Standards Review Council—Request for Nominations for Public Member Positions (January 30, 1978—43 FR 3944)

14. Notice—Virginia Statewide Professional Standards Review Council—Request for Nominations for Public Member Positions (January 30, 1978—43 FR 3945)

15. Notice—Designation of Professional Standards Review Organization for PSRO Area I (January 31, 1978—43 FR 4118)

16. 42 CFR Part 405—Deletion of Obsolete Regulations (February 2, 1978—43 FR 4428)

17. 42 CFR Part 449—Federal Financial Participation in State Claims for Abortions (February 2, 1978—43 FR 4571)

18. 42 CFR Part 481—Rural Health Clinics: Conditions for Certification (February 8, 1978—43 FR 5373)

19. 42 CFR Part 405—Health Maintenance Organizations—Reimbursement of Reinsurance Costs for Risk-Basis Health Maintenance Organizations (February 10, 1978—43 FR 5822)

20. 42 CFR Parts 405 and 449—Health Maintenance Organizations and State Medicaid Contracts (February 10, 1978—43 FR 5823)

21. Notice—Revocation of Supplement D of Handbook of Public Assistance Administration (February 13, 1978—43 FR 6165)

22. 42 CFR Part 463—Assumption of Review Responsibilities by Conditional Professional Standards Review Organizations, Conclusive Effect of PSRO Determinations on Claims Payment; Correlation of Title XI Functions With Functions Required Under Title XVIII and Title XIX of the Act (February 22, 1978—43 FR 7400)

23. 42 CFR Part 405—Quality Control and Proficiency Testing Standards for Laboratories in Medicare Hospitals (February 27, 1978—43 FR 7984)

24. 42 CFR Part 449—Inpatient Psychiatric Facility/Program Certification for Individuals Under 21 (February 27, 1978—43 FR 7985)

25. 42 CFR Part 405—Coverage and Reimbursement of Rural Health Clinic Services (March 1, 1978—43 FR 8258)

26. 42 CFR Part 449—Prohibition Against Reassignment of Provider Claims (March 3, 1978—43 FR 8800)

27. 42 CFR Part 450—Reasonable Cost Reimbursement of Inpatient Hospital Services (March 3, 1978—43 FR 8801)

28. 42 CFR Parts 448 and 449—Medicaid Eligibility—Various Provisions To Implement Recent Statutory Changes and To Clarify Existing Rules (March 10, 1978—43 FR 9810)

29. 42 CFR Part 450—Medicaid Claims Processing Systems: Explanation of Benefit Notices (March 10, 1978—43 FR 9817)

30. Notice—Statewide Professional Standards Review Council of California—Request for Nominations for Public Member Positions on the Council (March 22, 1978—43 FR 11857)

31. Notice—Statewide Professional Standards Review Council of Pennsylvania—Request for Nominations for Public Member Positions on the Council (March 22, 1978—43 FR 11858)

32. Notice—Systems of Records and Notice of Proposed Routine Uses (March 23, 1978—43 FR 12088)

33. 42 CFR Part 450—Medicaid Quality Control Systems; Expansion of Information Requirements (March 31, 1978—43 FR 13574)

HEALTH CARE FINANCING ADMINISTRATION

Index of Administrative Staff Manuals and Instructions

The Freedom of Information Act, as amended (Public Law 93–502) requires each government agency to make available for public inspection and copying all administrative staff manuals and instructions to staff which affect any member of the public. In order to give the public an understanding of what material is thereby available, agencies must provide a regularly updated index of pertinent titles. This index itself, like the manuals and other materials it lists, is required by law to be available to the public for inspection and copying upon request.

The Index will be maintained in all Health Care Financing Administration Regional offices where it may be examined by members of the public. The office will supply photocopies of selected pages upon request. (There may be a fee charged for this service, depending on the quantity of material requested.)

Any questions regarding this index should be made in writing to:

HCFA
Medicare Bureau
Office of Program Policy
6401 Security Boulevard
Baltimore, Maryland 21235

274-502 O - 78 - 10

PART A INTERMEDIARY MANUAL AND LETTERS

The Part A Intermediary Manual and Letters are designed for Medicare intermediaries. These are public or private agencies or organizations which process claims from providers of services, e.g., hospitals, skilled nursing facilities and home health agencies under the Medicare Program. The Manual and associated letters encompass the policies and procedures which govern intermediaries in carrying out their administrative and financial responsibilities for claims review, bill payment, applying utilization safeguards, and other responsibilities assigned them in connection with administration of the Medicare Program. Copies of the manual and letters may be requested in all Health Care Financing Administration Regional Offices.

Part 1—Fiscal Administration

Part 2—Audits—Reimbursement—Program Administration

Part 3—Claims Process

MEDICARE CARRIERS MANUAL AND LETTERS

The Medicare Carriers Manual and Letters are designed for use by organizations, primarily private insurers, which have contracted with the Secretary of Health, Education, and Welfare to act as carriers in administering the Medical Insurance part of Medicare (i.e., the part which helps pay for doctor's services, outpatient care, physical therapy, home health care, and other health services and supplies not covered by Medicare's hospital insurance). The Medicare Carriers Manual and associated Letters encompass the policies and procedures which govern carriers in performing their administrative and financial responsibilities for claims review, bill payment, applying utilization safeguards and other responsibilities assigned them in connection with Administration of the Medicare Program. Copies of the manual and letters may be requested in all Health Care Financing Administration Regional Offices.

Part 1—Fiscal Administration

Part 2—Program Administration

Part 3—Claims Process

CARRIER QUALITY ASSURANCE PROGRAM HANDBOOK AND BULLETINS

The CQ Handbook contains carrier processing and systems instructions for evaluating the quality of Part B claims adjudication. The Bulletins serve a temporary informational purpose, containing items of interest which will be manualized shortly.

INTERMEDIARY LETTERS (PART A AND/OR PART B)

HOSPITAL MANUAL

The Hospital Manual is issued to hospitals participating in the Medicare program and contains the policies and procedures applicable to the delivery of hospital services, claims processing instructions, billing procedures, coverage requirements, and related matters governing hospital performance under the Medicare program. Copies of the manual are available for inspection and copying in all Health Care Financing Administration Regional Offices.

MEDICARE FOREIGN HOSPITAL SUPPLEMENT

CHRISTIAN SCIENCE SANATORIUM HOSPITAL MANUAL SUPPLEMENT

SKILLED NURSING FACILITY MANUAL

This manual is issued to skilled nursing facilities participating in the Medicare program and contains the policies and procedures applicable to the delivery of skilled nursing facilitiy services to Medicare beneficiaries, claims processing instructions, billing procedures, coverage requirements and related matters governing skilled nursing facility performance under the Medicare program. Copies of the manual are available for inspection and copying in all Health Care Financing Administration Regional Offices.

HOME HEALTH AGENCY MANUAL

The Home Health Agency Manual is issued to home health agencies participating in the Medicare program and contains the policies and procedures applicable to the delivery of home health services to Medicare beneficiaries, claims processing instructions, billing procedures, coverage requirements and related matters governing home health agency performance under the Medicare program. Copies are available for inspection or copying in all Health Care Financing Administration Regional Offices.

OUTPATIENT PHYSICAL THERAPY PROVIDER MANUAL

The Outpatient Physical Therapy Provider Manual is issued to providers of physical therapy services participating in the Medicare program, and contains the policies and procedures applicable to the delivery of physical therapy services to Medicare beneficiaries, claims processing instructions, billing procedures, coverage requirements and related matters governing out-patient physical therapy providers performance under the Medicare program. Copies are available for copying and inspection in all Health Care Financing Administration Regional Offices.

General Information About the Program	I
Coverage of Services	II
Billing Procedures	III
Index	IV

GROUP PRACTICE PREPAYMENT PLAN MANUAL AND LETTERS

The Group Practice Prepayment Plan Manual and Letters contain policies and procedures governing the claims processing and billing functions of group practice prepayment plans providing services to Medicare beneficiaries under arrangements with the Administration. Copies of the manual and letters are available for inspection and copying in all Health Care Financing Administration Regional Offices.

General Information About the Health Insurance Program	1
Coverage and Limitations	II
Information Exchange Systems in Direct Dealing Plans	III
Reimbursement to Direct Dealing Plans	IV
Carrier Dealing Plans	V
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STATE BUY-IN HANDBOOK AND STATE BUY-IN LETTERS

The State Buy-In Handbook and State Buy-In Letters contain policies and procedures governing States having agreements with the Administration which the States must follow in enrolling and paying premiums for Medicare beneficiaries who are eligible under title XVI or XIX for State assistance in meeting their medical insurance premium liability under Medicare. Copies are available for inspection and copying in all Health Care Financing Administration Regional Offices.

Public Law 89–487

Background and Requirements	I
Systems Operations	II
Data Exchange	III
Buy-In Transaction Codes	IV
SSA/State Coordination—Organizational Responsibility	V
Miscellaneous Information and Exhibits	VI

HEALTH INSURANCE REGIONAL OFFICE MANUAL

The Health Insurance Regional Office Manual contains administrative and procedural instructions to Health Insurance Regional Offices in the areas of Medicare program responsibility assigned to their administrative level. Copies may be requested in any Health Care Financing Administration Regional Offices.

Contract Administration	I
Program Relationships	II
Claims Process	III
Program Review	IV
Provider Reimbursement	V
Provider Certification, Tie-in, and Termination	VI
Direct Dealing Providers and GPPP's	VII
Fiscal Administration	VIII
Medicare Appeals	IX
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IDENTICAL MEMORANDUMS

Identical Memorandums are temporary instructions which are issued to Medicare Bureau regional offices and are intended either to become obsolete or reissued as manual instructions within a short period of time. Identical Memorandums inform their audience of, for example, studies, meetings, training sessions, reporting requirements, projections and other program matters. Copies may be requested in all Health Care Financing Administration Regional Offices.

Administrative Audits, Appraisals, Review
Chronic Renal Disease
Claims Process
Contract Administration
Coverage
Disclosure
Health Maintenance Organizations
Professional Standards Review
Program Experimentation
Program Integrity and Validation
Reconsideration and Hearing
Recovery
Reimbursement
State Buy-In
Waiver of Liability

DEFICIENCY REPORTS ON PROVIDER SURVEYS (SSA–2567)

Deficiency Reports on Provider Surveys are summaries of the specific findings of noncompliance with Medicare conditions of participation identified in the periodic surveys of each participating provider of service, e.g., hospital, skilled nursing facility and home health agency. Copies may be requested in all Health Care Financing Administration Regional Offices.

ANNUAL CONTRACTOR EVALUATION REPORTS

Annual Contractor Evaluation Reports are prepared by Health Insurance Regional Offices, based on annual reviews of each contractor and summarize the effectiveness of each contractor's performance under the specific terms of its agreement with the Secretary. Copies may be requested in all Health Care Financing Administration Regional Offices.

PROGRAM VALIDATION STUDIES

Program Validation Studies are periodically issued summaries of the findings of onsite validation teams, who are responsible for reviewing selected aspects of the Medicare program functions of providers of services, e.g., hospitals, skilled nursing facilities and home health agencies, as well as intermediaries and carriers, primarily to determine the effectiveness of current policies and procedures in the program areas being investigated. Copies may be requested in all Health Care Financing Administration Regional Offices.

PREVAILING CHARGE SCREENS

Prevailing charge screens represent the highest allowable charges Medicare will recognize in various geographical areas for determining medical insurance benefits payable for physician and supplier services covered by the program. The prevailing charge screens are updated in July of each year and show for each covered service or supply the prevailing charge applicable for that service or supply in specified geographical areas. Copies can be requested in all Health Care Financing Administration Regional Offices.

PROVIDER COST REPORTS

Provider Cost Reports are submitted, on an accounting year basis, by each participating provider of service, i.e., hospital, skilled nursing facility and home health agency. These reports summarize all relevant costs by the provider and are the basis for determination of costs reimbursable under the Medicare program. Copies may be requested in writing from the provider's fiscal intermediary, or from the Health Care Financing Administration Regional Offices.

PROVIDER REIMBURSEMENT MANUAL

This Provider Reimbursement Manual describes the various methods used and the expenses which are allowable in computing reasonable cost reimbursement for providers of services, e.g., hospitals, skilled nursing facilities and home health agencies and, for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency or public health agency, participating in the Medicare program. Copies are available for inspection and copying at all Health Care Financing Administration Regional Offices.

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Part II

Provider Cost Reporting Forms and Instructions

GROUP PREMIUM PAYMENT HANDBOOK AND GROUP PREMIUM LETTERS

The Group Premium Payment Handbook and Group Premium Letters contain the policies and procedures governing the group payment of Medicare insurance premiums and are issued to various groups and organizations which pay the premiums for their members for voluntary hospital insurance and supplementary medical insurance under Medicare. Copies are available for inspection and copying at all Health Care Financing Administration Regional Offices.

PROGRAM CIRCULARS

Health Insurance program circulars are issued by the Medicare Bureau as well as by the various regional offices for two purposes: 1) to alert personnel to new program developments prior to the issuance of new manual sections; and 2) to clarify existing policies and procedures which have been issued in manual form. Copies of the circulars are maintained in Health Care Financing Administration offices and are available for inspection and copying there.

PART B MODEL SYSTEM

This is a software computer system available to carriers for processing Part B claims. The system contains the necessary programming for carriers to review bill payments applying utilization safeguards and other responsibilities assigned to them. Copies may be requested in all Health Care Financing Administration Regional Offices.

DIRECTORY OF MEDICAL FACILITIES

The Director of Medical Facilities is a listing of providers (participating hospitals, emergency hospitals and those which can continue a benefit period (spell of illness); participating skilled nursing facilities and home health agencies). It also lists the intermediaries which process provider claims.

MAGNETIC TAPE SPECIFICATIONS HANDBOOK

The Magnetic Tape Specifications Handbook supplies intermediaries with the standards and criteria they must use in submitting bills on magnetic tape rather than on hard copy.

CLAIMS MANUAL

The Claims Manual is a publication of the Social Security Administration which contains the policies and instructions for SSA. However, included in the Claims Manual, Parts 10 and 11, are instructions concerning the responsibilities of the components administering Medicare; entitlement requirements for Part A-Hospital Insurance and Part B-Supplementary Medical Insurance benefits; instructions and policies to resolve entitlement problems; monthly premium amounts and premium collection policies and procedures; termination of entitlement; policies and procedures for the filing of claims, recovering overpayments, making underpayments, waiver of liability provisions, Medicare appeals, and in general, policies dealing with definitions; e.g., hospital services, physician, benefit period, medical necessity, as well as identifying services which by law are excluded from coverage. Copies of these sections of the Claims Manual are maintained in all Health Care Financing Administration Regional Offices and are available for inspection and copying there.

MEDICARE BUREAU

DELEGATION OF AUTHORITY

Giving appropriate positions in Bureau of Health Insurance, Bureau of Data Processing and Regional Offices authority to make decisions in the adjudication of Health Insurance and Supplementary Insurance claims. (3/15/67—Doc. No. 4309.3)

Authority to determine and authorize amounts for payment to individuals. Authority to certify amounts for payment (Medicare). (4/17/67—Doc. No. 4309.5)

Formalize delegations aspect which permits an intermediary or carrier to merge title XVIII and complementary insurance claims processes. (12/20/67—Doc. No. 3772.8)

Delegation of authority to authorize and certify payments with respect to direct reimbursement operations. (5/2/68—Doc. No. 4309.12)

Revision of title XVIII redelegation relating to administration of contracts with group practice prepayment plans. (6/13/68—Doc. No. 4309.22)

Revised delegations of authority to align with positions in reorganization of the Bureau of Health Insurance. (7/3/69—Doc. No. 4309.36)

Delegation of authority to Bureau of Health Insurance to facilitate administration of agreements with providers of services. (1/5/70—Doc. No. 4309.41)

Delegated to Regional Commissions certain title II and title XVIII authorities. (6/5/70—Doc. No. 4309.47)

Delegation of authority to contract with accounting firms for audits of direct-dealing providers. (10/20/71—Doc. No. 6331–d)

Revisions in delegations of authority due to reorganization of the Bureau of Health Insurance. (3/8/72—Doc. No. 4309.60)

Modifications in delegations of authority under title XVIII to Bureau of Health Insurance positions. (9/14/72—Doc. No. 4309.69)

Modifications in delegations of authority to determine amounts due and authorize payments to Medicare contractors. (7/9/73—Doc. No. 4309.79)

Delegations of authority under title XVIII to Program Officers in Bureau of Health Insurance Regional Offices. (8/2/73—Doc. No. 4309.82)

Delegation of authority relative to Health Maintenance Organizations and Group Practice Prepayment Plans. (8/17/73—Doc. No. 4309.84)

New and modified delegations of authority under section 1862 and 1866 of title XVIII. (9/20/73—Doc. No. 4309.87)

Delegated authority to compromise claims for overpayments which do not exceed $20,000. (3/14/74—Doc. No. 5913–mm)

Additional delegations of authority under title XVIII to Chief, Contract Financial Management Branch, Bureau of Health Insurance. (3/29/74—Doc. No. 4309.100)

Delegation of authority to administer oaths and affirmations in the course of hearings, investigations or other proceedings under title XVIII. (4/15/74—Doc. No. 4309.101)

Delegated to claim examiners (Health) Division of Direct Reimbursement authority to make findings of fact and decision which affect rights of individuals. (5/30/74—Doc. No. 4309.102)

Modifications in delegations of authority under title XVIII relating to providers and suppliers of services. (10/18/74—Doc. No. 4309.115)

Delegation of authority relative to validation of hospital surveys made by Joint Commission and American Osteopathic Association. (10/21/74—Doc. No. 4309.116)

Delegation of authority to establish negotiated payment rates with independent laboratories. (12/5/74—Doc. No. 4309.117)

CLAIMS PROCESSING:

Delegation of authority to make decisions in adjudication of Health Insurance and Supplemental Medical Insurance claims. (3/15/67—Doc. No. 4309.3)

Relief to be given in meritorious situations to pay supplementary medical insurance premiums after the end of grace period. (5/29/67—Doc. No. 6354–b)

Policies pertaining to determination of amount of Part A benefits in controversy. (10/4/67—Doc. No. 6355–e)

Determination that Amish Hospital Aid Plan is not insurance within meaning of section 1402(h) of Internal Revenue Code. (10/11/67—Doc. No. 6344–b)

Approval of financial policies with respect to exchanges of title XVIII claims information for complementary insurance purposes. (2/19/68—Doc. No. 3772.29)

Delegation of authority to authorize and certify payments with respect to direct reimbursement operations. (5/2/68—Doc. No. 4309.12)

Termination of recovery of certain overpayments of supplementary medical insurance. (10/7/74—Doc. No. 6362–e)

Approved policy that SSA deduct any unpaid supplementary medical insurance (SMI) premium(s) owed by a beneficiary enrollee from the first title II benefit check payable to that enrollee (or to his estate) from which such deduction is administratively feasible. (4/25/75—Doc. No. 6354–y)

PROVIDERS OF SERVICES, INTERMEDIARIES AND CARRIERS:

To furnish copies of microfilm listings of health insurance beneficiaries to intermediaries and carriers. Contents limited. (6/13/67—Doc. No. 3772.17)

Relating to the effective date of provider agreements with institutions that wish to participate as providers of services. (1/18/67—Doc. No. 6346–c)

Authority to determine and authorize amounts for payment to individuals (supplementary medical insurance) and authority to certify amounts for payment to individuals (direct dealing providers). (4/17/67—Doc. No. 4309.5)

Concurrence in recommendation to permit merging of title XVIII and complementary insurance claims processing. (9/22/67—Doc. No. 3772.23)

Delegation of authority to grant or deny termination of participation on less than 6 months notice and to determine effective date of such termination. (9/25/67—Doc. No. 6346–d)

Delegation of authority to contract, authorize payments, approve subcontracts. (9/25/67—Doc. No. 4309.13)

Delegation of authority to approve integration of title XVIII and complementary insurance claims processes. (12/20/67—Doc. No. 3772.8)

Concurred in recommendation to permit combining of complementary insurance notices with title XVIII notices. (5/25/68—Doc. No. 3772.31)

Revision of title XVIII redelegations relating to administration of contracts with Group Practice Prepayment Plans. (6/13/68—Doc. No. 4309.22)

Revised delegation of authority to approve subcontracts, purchases, and leases by intermediaries. (10/9/68—Doc. No. 4309.29)

Policy on intermediary availability and provider requests for change of intermediary. (11/22/68—Doc. No. 6349–c)

Delegation of authority to approve requests by providers of services to terminate participation agreements on less than 6 months' notice. (2/5/69—Doc. No. 6346–h)

Requests by carriers for copies of microfilm listings of health insurance beneficiaries for processing title XVIII claims. (4/3/69—Doc. No. 3772.37)

Delegation of authority to enable Bureau of Health Insurance to implement policies directed toward effective administration of agreements with providers. (1/5/70—Doc. No. 4309.41)

Pilot Program authorized to determine feasibility of accepting cost reports certified by a hospital's independent auditor. (1/9/70—Doc. No. 6342–p)

Delegation of authority to contract with accounting firms for audits of direct-dealing providers. (10/20/71—Doc. No. 6331–d)

Approved issuances of telegrams to intermediaries and provider organizations re Price Commission Ruling 1972–267 upon Medicare reasonable cost reimbursement. (2/13/73—Doc. No. 6342–tt)

GENERAL:

Allocation of administrative costs for furnishing title XVIII claims information to State Welfare Agencies or their agents. (12/27/67—Doc. No. 6354–c)

Determination to continue the Medical Advisory Committee. (5/31/68—Doc. No. 6310–g)

Contract out the responsibility for the maintenance of Part B model data processing system for another year. (10/28/69—Doc. No. 6360–a)

Since title V, XVIII and XIX are all required to reimburse hospitals, implementation of common audits was approved. (5/27/70—Doc. No. 6342–r)

Amendments to decision regarding implementation of common audits for title V, XVIII and XIX. (5/5/71—Doc. No. 6342–dd)

Securing competitive bids for further contracting out of maintenance function of Supplementary Medical Insurance Model System. (5/3/71—Doc. No. 6360–b)

Approval of model agreement in carrying out provisions of section 1122 of Social Security Act (Limitation on Federal Participation for Capital Expenditures). (3/22/73—Doc. No. 6346–m)

MEDICAID BUREAU

ACTION TRANSMITTALS

The Action Transmittals are designed to transmit policies of the Medicaid Bureau to individuals that participate and administer the Medicaid program. A numeric listing of the Action Transmittals are:

*SRS–AT–75–9	—	Title XIX UR
SRS–AT–75–14	—	Contracts for Providing Payments for Services
SRS–AT–75–21	—	Coverage Prior to Application for Medicaid; Answers to Questions
SRS–AT–75–25	—	Medicaid Physician Reimbursement Report
SRS–AT–75–31	—	Blindness as a Condition of Eligibility
SRS–AT–75–35	—	Quality Control—Title XIX
SRS–AT–75–42	—	Relationship of PSRO Review Responsibilities to Medicaid
SRS–AT–75–47	—	UC Reg. Partial Postponement
SRS–AT–75–48	—	Deferral of Effective Date of UR
SRS–AT–75–50	—	Medicaid Staffing Guide
SRS–AT–75–51	—	Payments to Renal Facilities
SRS–AT–75–52	—	Extension of the Pass-Along Provision Section 249E of P.L. 92–603
SRS–AT–75–57	—	Remote Facility Variances (UR)
SRS–AT–75–59	—	Remote Facility Variances (UD)
SRS–AT–75–60	—	Physicians Services—Limitation on Prevailing Charges FY76
SRS–AT–75–65	—	UR—Partial Indefinite Deferral
SRS–AT–75–72	—	Generic Drugs (MAC)
SRS–AT–75–75	—	EPSDT Penalty Application
SRS–AT–75–76	—	Home Health Service
SRS–AT–75–81	—	Change No. 3–1, Medicaid Eligibility Q.C. Manual

* Prior to 3/8/77, these Action Transmittals were issued in the instrucional system of the Social and Rehabilitation Service. The reorganization order of the Secretary of HEW of 3/8/77, transferred the Title XIX program to the new Health Care Financing Administration.

SRS–AT–75–85	—	UC—Postponement of Effective Date of Certain Provisions (Refer to SRS–AT–75–48 and 65)
SRS–AT–75–87	—	Home Health Services—Extension of Comment Period (Refer to SRS–AT–75–76)
SRS–AT–75–94	—	Definition of SNF Care
SRS–AT–75–109	—	Titles XVIII and XIX, SSA: Definitions of SNF Care
SRS–AT–75–115	—	Tilte XIX, SSA: Transfer of Certain Authorities with Respect to Standards for SNF and ICF
SRS–AT–75–116	—	Title XIX, SSA: Reserved Beds in Long-Term Care Facilities
SRS–AT–75–117	—	Title XIX, SSA: PP State Plan Amendment Freedom of Choice: Exemption for P.R., Guam, V.I.; and Expiration of Certain "Pass-Along" Provisions
SRS–AT–75–118	—	Tilte XIX, SSA: PP State Plan Amendment for Payments for Reserved Beds in Long-Term Care Facilities
SRS–AT–75–122	—	Title XIX, SSA: UC: Certification/Recertification
SRS–AT–75–124	—	Payment for Multiple Source Drugs (Title XIX, SSA)
SRS–AT–75–125	—	PP State Plan Amendments for Continued Eligibility of Certain Individuals and Changes in "Pass-Along" of Specified OASDI Benefits
SRS–AT–75–135	—	Relative Responsibility—Medicaid
SRS–AT–76–1	—	Clarification of Requirements for Coverage of Certain SSI Recipients; Date of Application for Medicaid; Application of SSI Criteria in State Determination of XIX Eligibility
SRS–AT–76–6	—	Tilte XIX: Inpatient Psychiatric Facility Services for Individuals Under 21
SRS–AT–76–13	—	Title XIX: MA Manual—ICF Services Upper Limit: Reasonable Differential Between Costs of SNF & ICF Services
SRS–AT–76–14	—	State Consent to Suit

SRS–AT–76–16	—	Prohibition Against Reassignment of Claims
SRS–AT–76–20	—	Title XIX, SSA: Preprinted State Plan Amendment Relating to Payment for Drugs
SRS–AT–76–21	—	Inpatient Psychiatric Services for Individuals Under 21
SRS–AT–76–30	—	Proposed Uniform Hospital Discharge Abstract (UHDA)
SRS–AT–76–36	—	Implementation of Section 2(d) of the Revenue Adjustment Act of 1975—Disregard of Earned Income Credits
SRS–AT–76–39	—	Title XIX—Preprinted State Plan Amendment on Standards for Personnel Administration
SRS–AT–76–48	—	ICF Resident Rights
SRS–AT–76–50	—	Hospital UR-Medicaid
SRS–AT–76–52	—	Location of Fraud Certification Statement
SRS–AT–76–53	—	Criteria for Approval of Alternative Methods of Reimbursement for Inpatient Hospital Services
SRS–AT–76–61	—	Title XIX: Reimbursement, SNF & ICF
SRS–AT–76–64	—	Plan Amendment on Cost Allocation, Title XIX
SRS–AT–76–65	—	MSA Med. Assistance Manual: Coverage & Eligibility, Families and Children
SRS–AT–76–66	—	FFP, Costs of Support Staff, Title XIX
SRS–AT–76–68	—	Limitations on Coverage of Inpatient Hospital Costs
SRS–AT–76–77	—	UR in SNF: State Requests for Waiver of Title XVIII Requirements
SRS–AT–76–78	—	Proposed Regulations, Reimbursement of LTCF
SRS–AT–76–79	—	UC Survey: Periodic Medical Inspections
SRS–AT–76–82	—	Limitation of Payment or Reimbursement for Drugs
SRS–AT–76–86	—	Medicaid/Head Start Program Collaboration
SRS–AT–76–87	—	Title XIX: Inpatient Psychiatric Facility Services Individual Under 21

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SRS–AT–76–88	—	UC: Format of Quarterly Showing
SRS–AT–76–90	—	MSA MA Manual: 3rd Party Liability Resources
SRS–AT–76–92	—	WIN
SRS–AT–76–93	—	UC
SRS–AT–76–94	—	PSRO: Physician Certification of Need for Institutional Care
SRS–AT–76–95	—	SNF Participation in Medicare
SRS–AT–76–96	—	UC
SRS–AT–76–98	—	Residence Requirements in MAP
SRS–AT–76–100	—	Termination of Federal Matching for Inpatient Care Title XIX
SRS–AT–76–102	—	Reporting of Provider Fraud
SRS–AT–76–103	—	State Plan Amendment on Fraud
SRS–AT–76–104	—	MSA MA Manual: Coverage and Conditions of Eligibility—Optional Coverage
SRS–AT–76–105	—	MSA MA Manual, Required Coverage Eligibility ABD
SRS–AT–76–106	—	MSA MA Manual Continued Medicaid Coverage—Eligibility
SRS–AT–76–107	—	Cost Related Reimbursement of SNF & ICF Services
SRS–AT–76–109	—	Eligibility—Optional Coverage of Medically Needy
SRS–AT–76–110	—	Eligibility—Special Provision Regarding Persons in Title XIX and Public Institutions
SRS–AT–76–111	—	Appeals from PSRO Decision
SRS–AT–76–113	—	SNF Services, Reimbursement
SRS–AT–76–114	—	State Consent to Suit
SRS–AT–76–115	—	Current Requirements for UR in Hospitals
SRS–AT–76–116	—	Cost-related Reimbursement for SNF and ICF Services
SRS–AT–76–120	—	Medicaid Payments for Swine Influenza Vaccinations
SRS–AT–76–121	—	Verification of Services to Recipients
SRS–AT–76–123	—	Inpatient Psychiatric Services Under 21

SRS–AT–76–126	—	Title XIX, SSA: 1) Inpatient Psychiatric Facility Services of Individual Under 21 2) Reporting of Provider Fraud
SRS–AT–76–129	—	Home Health Services
SRS–AT–76–130	—	Home Health
SRS–AT–76–131	—	Notice of Intent to Consider Changes in DHEW Home Health Services Programs
SRS–AT–76–133	—	Medicaid Prohibition Against Reassignment of Claims Factoring
SRS–AT–76–134	—	Medicaid Prohibition Against Reassignment of Claims Factoring
SRS–AT–76–135	—	UC: Survey to Determine Adherence to Section 1903(g) and Quarter Showing Clarification of SRS–AT–76–69 and SRS–AT–76–88
SRS–AT–76–137	—	Subject Outline and Summary of Required and Optional Coverage Groups
SRS–AT–76–139	—	Reasonable Cost Reimbursement of Inpatient Hospital Services
SRS–AT–76–140	—	Involvement of State Medicaid Agencies in PSRO Implementation
SRS–AT–76–141	—	PSRO Review Responsibility to the Program—Financial Penalties
SRS–AT–76–142	—	Development of Model State Medicaid Information Pamphlets and Eligibility Forms
SRS–AT–76–143	—	WIN Program Child Care and Supportive Services
SRS–AT–76–146	—	Request for Information of Status of Developmental Assessment Component of the EPSDT Program
SRS–AT–76–147	—	Inpatient Psychiatric Services for Individual Under Age 21
SRS–AT–76–153	—	MSA Assistance Manual; Coverage and Conditions of Eligibility—ABD
SRS–AT–76–155	—	Title XIX: UC Qtrly. Showings, Modifications to SRS–AT–76–88
SRS–AT–76–157	—	F & A Reporting: Extension of Forms NCSS 119.1 and 119.2

SRS–AT–76–163	—	Title XIX: PP State Plan Amendment—Repeal of State Consent to Suit Requirement
SRS–AT–76–166	—	Limitations of FFP for Capital Expenditures, Title XIX
SRS–AT–76–169	—	Title XIX: Limitations on Coverage of Inpatient Hospital Costs
SRS–AT–76–170	—	Refer to SRS–AT–76–169
SRS–AT–76–171	—	Title XIX: Upper limits for Payments to Individual Practitioners
SRS–AT–76–176	—	Title XIX: Definition of Annual—Periodic Med. Review and Independent Professional Review
SRS–AT–76–181	—	Title XIX: Fed. Financing of PSRO Hosp. Review (refer to AT 75–42)
SRS–AT–76–183	—	Q.C.: Review of Negative Case Action
SRS–AT–77–3	—	Title XIX: Reimbursement for Medical Services, Supplies, Equipment
SRS–AT–77–4	—	Title XIX: Determination of Income and Resources of Spouses and Parents Available to Applicants for/or Recipients of Medical Assistance
SRS–AT–77–6	—	Title XIX: Revision of PP for State MA Program Consideration of Income and Resources of Spouses and Parents Available to Applicants for/or Recipients of Medical Assistance
SRS–AT–77–8	—	Title XIX: Standards for Services in ICF for Mentally Retarded
SRS–AT–77–9	—	Title XIX: UC Quarterly Showing
SRS–AT–77–10	—	Title XIX: LTCF—Termination of FFP
SRS–AT–77–12	—	Title XIX: Termination of Federal Matching of Payments for Inpatient Care
SRS–AT–77–13	—	Title XIX: Revision of Fire Safety Requirements for ICF
SRS–AT–77–26	—	MSA MA Manual: Home Health Services
SRS–AT–77–31	—	Title XIX: ICF for Mentally Retarded
SRS–AT–77–32	—	Change #3–1 MEQC Manual
SRS–AT–77–35	—	Physicians Services—Billing for Lab or Radiological Services

SRS–AT–77–38	—	Patient Assessment and Evaluation in LTC
SRS–AT–77–43	—	Title XIX: Elements for Assessment of State Plans for Monitoring Conditional PSROs
SRS–AT–77–48	—	Title XIX: State Medicaid Agency Monitoring of PSROs
SRS–AT–77–49	—	Submittal of Draft Medicaid Minimum Data Set (MDS) for Comment
SRS–AT–77–50	—	Title XIX: Limitation of FFP for Capital Expenditures
SRS–AT–77–51	—	MSA Med. Assistance Manual: Mental Health Care in SNF and ICF for Mental Diseases
SRS–AT–77–52	—	Title XIX: Relationship Between Medicaid and CHAMPUS on double Coverage of Recipients
SRS–AT–77–56	—	Title XIX, SS Act: Recent Statutory Changes Related to Medicaid Eligibility
SRS–AT–77–61	—	Title XIX, SS Act: Maximum Allowable Cost for Multiple Source Drugs Ampicillin
SRS–AT–77–62	—	MSA Medical Assistance Manual Third-Party Liability Resources
SRS–AT–77–63	—	Title XIX, SS Act: ICF for Mentally Retarded
SRS–AT–77–64	—	Nondiscrimination on Basis of Handicap in Programs and Activities Receiving or Benefitting from Federal Financial Assistance
SRS–AT–77–65	—	Repayment of Federal Funds by Installments
SRS–AT–77–66	—	Transitional Procedures NCSS
SRS–AT–77–71	—	Title XIX, SS Act: PP State Plan Amendment of ICF Services for the Mentally Retarded
SRS–AT–77–72	—	Standards of Personnel Administration for the Medicaid Program: Final Regulations

HCFA–AT–77–73	—	Title XIX, SS Act: Responsibility of State Title XIX Plan, Title XVIII, Part A Deductibles and Coinsurance Amounts
HCFA–AT–77–74	—	List of Fiscal Agents and Health Insuring Agencies
HCFA–AT–77–75	—	MSA MA Manual: FFP in Staffing Costs for Mechanized Claims Processing and Information Retrieval Systems
HCFA–AT–77–76	—	Q C of Negative Case Actions in Medicaid
HCFA–AT–77–77	—	Extension of the Earned Income Credit Under the Tax Reduction and Simplification Act of 1977. (Refer to SRS–AT–76–186 & SRS–AT–77–25)
HCFA–AT–77–78	—	Title XIX, SS Act: Supplement D of the Handbook of Public Assistance Administration
HCFA–AT–77–79	—	Standards of Personnel Administration for the Medicaid Program: Final Regs. (Correction) (Refer to AT–77–72)
HCFA–AT–77–80	—	Medicaid Eligibility for Western Hemisphere Aliens (Silvav. Levi)
HCFA–AT–77–81	—	TITLE XIX, SSA: PP STATE PLAN AMENDMENT Standards of Personnel Administration (Merit Systems Requirements.) (Refer to AT–77–72)
HCFA–AT–77–82	—	Reporting Expenditures of Indian Health Care Facilities for Medicaid Eligibles on a separate form SRS–OA–41.9.
HCFA–AT–77–83	—	Title XIX, SSA: PP State Plan Amendment on Nondiscrimination on the Basis of Handicap. (Refer to IM–77–21, AT–77–64, IM–77–34.)
HCFA–AT–77–84	—	Court Decisions on Abortions Under Medicaid
HCFA–AT–77–85	—	MMB Med. Assistance Manual: Reimbursement on a Reasonable Cost-Related Basis for SNF and ICF Services (Refer to SRS–AT–76–107)

HCFA–AT–77–86	—	Reporting of Cash Transactions (Supersedes AA/M–OFM–P1–73–1)
HCFA–AT–77–87	—	Title XIX, SSA: Designation of Regional Office Authority for Medicaid Program Matters
HCFA–AT–77–88	—	MMB Med. Assistance Manual-Revision of Resource Requirements for the conditionally Eligible (Refer to SSA Claims Manual, Sect. 12570 and HCFA–AT–77–56.)
HCFA–AT–77–89	—	Title XIX, SSA: Penalty for Failure to Provide EPSDT.
HCFA–AT–77–90	—	Title XIX SSA: Payment for Reserved Beds in Institutions
HCFA–AT–77–91	—	Title XIX, SSA: UC: format Qtrly. Showings-Modification to SRS–AT–76–88 (Refer to Sect. 1903(g)(1), 1902(a)(26), and 1902(a)(31).)
HCFA–AT–77–92	—	Title XIX, SSA: PP State Plan Amendment on Payments for Reserved Beds (Refer to HCFA–AT–77–90.)
HCFA–AT–77–93	—	Title XIX, SSA: Disregard of Judgment Payments to Members of the Grand River Band of Ottawa Indians; Summary of Special Income Exclusions for Indians. (Refer to 20 CFR 416.1146(b), (c).)
HCFA–AT–77–94	—	Title XIX, SSA: UC-Survey to Determine Adherence to Sect. 1903(g) of the SSA During the Qtr. Ending 6/30/77 in Selected States. (Refer to Sect. 1902(a)(26) & (31); 1903(g)(1)(d).
HCFA–AT–77–95	—	Title XIX, SSA: Effective Date of Medicaid Regs. on Contracts
HCFA–AT–77–96	—	Title XIX, SSA: Designation of Reg. Office Authority for Medicaid Program Matters (Correction)
HCFA–AT–77–97	—	Transfer and Recodification of Regs of HCFA (Refer to 20 CFR Chapt. III, 42 CFR Chapt. I, 42 CFR Chapt. IV (new).)
HCFA–AT–77–98	—	Title XIX, SSA: Payment for Reserved Beds (Correction)

HCFA–AT–77–99	—	Affirmation of Continuing Reporting Requirement for Qtrly. Statements for Financial Plan (OA–25A & CA–25.5) Report Due 11–1–77
HCFA–AT–77–100	—	Address to be Used in Submitting Qtrly. Estimate of Expenditures (SRS–OFM–65) and Qtrly. Statement of Expenditures (SRS–OA–41) for the Medicaid Program.
HCFA–AT–77–101	—	Title XIX, SSA: P1 State Plan Amendment on QC System (Refer to HCFA–AT–77–66)
HCFA–AT–77–102	—	Title XIX, SSA: Responsibility of State Medicare Program Part A Deductibles and Coinsurance Amounts. (Supersedes HCFA–AT–77–73)
HCFA–AT–77–103	—	QC Review of Negative Case Actions Title XIX (Refer to HCFA–AT–77–76)
HCFA–AT–77–104	—	MMB Med Assistance Manual Revision of Resource Requirements for the Conditionally Eligible-Addendum to HCFA–AT–77–88 (Refer to Sect. 16(3)(a)(1), SSA
HCFA–AT–77–105	—	Establishing Administrative Procedures for Recovering Overpayments and Correcting Abusive Practices
HCFA–AT–77–106	—	Title XIX, SSA: Recent Statutory Amendments to Sect. 1903(g): UC
HCFA–AT–77–107	—	MMB Med. Assistance Manual: Coverage and Conditions of Eligibility-Citizenship and Coverage of Aliens
HCFA–AT–77–108	—	Title XIX, SSA: Surgical Second Option
HCFA–AT–77–109	—	Staffing Training in Medical Assistance Programs Title XIX, SSA (Refer to 45 CFR 205.202, Part 225)
HCFA–AT–77–110	—	Title XIX, SSA: Request for Internal Medicaid Program & Budget State Annual Reports (Refer to AT–77–49(MSA)
HCFA–AT–77–111	—	Use of the Uniform Health Insurance Claim Form by State Programs
HCFA–AT–77–112	—	Qtrly. Submission of Title XIX Reporting Forms 119.1 and 119.2
HCFA–AT–77–113	—	Title XIX, SSA: Limitation on Payment or Reimbursement for Drugs: Estimated Acquisition Cost

HCFA–AT–77–114	—	Title XIX, SSA: Reimbursement on a Reasonable Cost Related Basis for SNF & ICF Services
HCFA–AT–77–115	—	Title XIX, SSA: Restriction Applicable to Sterilizations
HCFA–AT–77–116	—	Request for Comments on Revised EPSDT Reporting Requirements; (2) Solicitation of Interest in Revewing (GSD) of a State EPSDT MMIS
HCFA–AT–77–117	—	EPSDT Immunization Initiative, FY 1978
HCFA–AT–77–118	—	Title XIX, SSA: PP State Plan Amendment on Staffing and Training in MAP's
HCFA–AT–78–1	—	Title XIX, SSA: PP State Amendment on Indian Health Service Facilities as Service Providers for Medicaid (Refer to HCFA–AT–77–120)
HCFA–AT–78–2	—	MMB Med. Assistance Manual Interrelations with State Health and Vocational Rehab. Agencies with Title V Grantees and with Other Providers

Information Memoranda

The Information Memoranda are policy instructions and other informational material as deemed necessary to Medicaid Program participants regarding certain aspects of the program that should be emphasized and elaborated upon because of problems which have been pointed out. A numeric listing of the Information Memoranda as it pertains to the Medical Assistance Administration, SRS is as follows:

*MSA–IM–71–2	—	Medicare Only Reimbursement for Physicians' Visits to NH Patients
MSA–IM–71–7	—	Recommended Training Program for NH Administrators

* The Medical Assistance Administration, formerly of the Social and Rehabilitation Service, was transferred to the new Health Care Financing Administration as a result of the reorganization order issued by the Secretary of HEW on March 8, 1977.

Numeric listing of Information Memoranda issued by the Social and Rehabilitation Service*

SRS–IM–75–7	—	Federal Matching for Health-Supportive Services in the EPSDT
SRS–IM–75–8	—	GAO Audit Report
SRS–IM–75–16	—	Available Technical Assistance for EPSDT
SRS–IM–75–22	—	Drug Reimbursement Under DHEW Programs
SRS–IM–75–26	—	Example of Sterilization Consent Form
SRS–IM–75–27	—	Subject Index to Regs in 45 CFR Parts 200–499, for Financial and MA Programs
SRS–IM–75–30	—	Meeting of State Medicaid Podiatry Consultants in D.C., 1–12–76
SRS–IM–75–32	—	3 Multi-Regional Meetings (Drug Regulations and Mental Health Problems)
SRS–IM–76–3	—	Reimbursement Under Title XIX, SSA for Services to the Chronically Ill and Compared in Alternative Settings
SRS–IM–76–4	—	Preliminary Agenda (and Selection of Workshops), Eighth Annual Conference of State Medicaid Program Directors, 3/23–25 Statler Hilton Hotel, D.C.
SRS–IM–76–5	—	Title XIX, SSA: Price Information for Drug Products
SRS–IM–76–8	—	Available Assistance to States from the American Academy of Pediatrics—EPSDT
SRS–IM–76–9	—	Title XIX, SSA: Rehabilitation Nursing Consultation to LTF
SRS–IM–76–11	—	Title XIX, Social Security Act: Draft Guidelines on Payment of Reasonable Charges for Prescribed Drugs
SRS–IM–76–14	—	LTC Improvement Campaign—Phase II
SRS–IM–76–18	—	Title XIX: Price Information for Drug Products
SRS–IM–76–19	—	Title XIX: "Evaluation of Medicaid Spend-Down"

* The Medical Assistance Administration, formerly of the Social and Rehabilitation Service was transferred to the new Health Care Financing Administration as a result of the reorganization order issued by the Secretary of HEW on March 8, 1977.

SRS–IM–76–22	—	Guidelines: Sect. 249, P.L. 92–603, Reimbursement. Related Basis for SNF and ICF
SRS–IM–76–23	—	Title XIX: Price Information for Drug Products
SRS–IM–76–25	—	Third-Party Liability Meeting, Chicago 7/28 to 7/29; State Medicaid Directors and MSA Regional Offices
SRS–IM–76–28	—	Medicaid Eligibility—Q & A
SRS–IM–76–31	—	Price Information for Drug Products (Refer to SRS–AT–75–72)
SRS–IM–76–32	—	Limitation on Coverage of Inpatient Hospital Costs
SRS–IM–76–38	—	Information Exchange Committee—State XIX Directors National Council
SRS–IM–76–39	—	Research—Hospital and Medical Economics and Health Care Organization and Administration
SRS–IM–76–40	—	Ninth Annual Conference of State Medicaid Directors
SRS–IM–76–41	—	Price Information for Drug Products
SRS–IM–76–43	—	Fraud and Abuse Control Seminar Nov. 11–12, 1976, Dallas, Texas
SRS–IM–76–45	—	Rehabilitation Nursing Consultation to LTCF
SRS–IM–76–46	—	Use of AMA Uniform Health Insurance Claim Form by State Programs
SRS–IM–76–47	—	Medicaid and Aging Agency Cooperative Agreements
SRS–IM–76–49	—	Title XIX: Recent Related Statutory Changes
SRS–IM–76–50	—	Title XIX: Price Information for Drug Products (Refer to AT–75–72)
SRS–IM–76–51	—	Title XIX: Registered Nurse Consultant to ICF
SRS–IM–76–56	—	List of Directors of Single State Agencies, Umbrella Agencies, MAU. (Superseded by IM–77–26)

SRS–IM–77–2	—	Title XIX: Price Information for Drug Products (Refer to SRS–AT–75–72 and SRS–IM–76–18)
SRS–IM–77–3	—	Institute for Medicaid Management (IMM)
SRS–IM–77–4	—	Erroneous Payments Conference San Francisco, California, February 23–24, 1977
SRS–IM–77–6	—	Ninth Annual Conference of State Medicaid Program Directors, March 8–11, 1977, Denver
SRS–IM–77–7	—	Third Party Liability/Benefit Recovery Multi-State Workshops
SRS–IM–77–9	—	Developmental Disabilities Assistance and Bill of Rights Act, P.L. 94–103
SRS–IM–77–10	—	Ninth Annual Conference, State Medicaid Directors, March 10, 1977, Denver, Colorado Medicaid Eligibility Workshop
SRS–IM–77–11	—	Proposed Legislative Changes in Title XIX: H.R. 3 and S. 143
SRS–IM–77–13	—	Federal and State Fraud and Abuse Control Contact Persons
SRS–IM–77–14	—	Title XIX: Price Information for Drug Products (Refer to SRS–AT–75–2 and SRS–IM–77–2)
SRS–IM–77–15	—	Title XIX: Third Multi-State S/UR Users Conference, April 13–14, 1977, Little Rock, Arkansas
SRS–IM–77–16	—	Meeting of State Medicaid Dental Consultants, Washington, D.C., May 20–21, 1977
SRS–IM–77–17	—	Addendum to 2/7/77 Memorandum: SRS–IM–77–9 Developmental Disabilities Assistance and Bill of Rights Act, P.L. 94–103
SRS–IM–77–17a	—	Title XIX: Price Information for Drug Products (Refer to SRS–AT–75–72 and SRS–IM–76–18)
SRS–IM–77–20	—	Title XIX: Alternative Methods of Reimbursement for Hearing Aids and Eyeglasses
SRS–IM–77–21	—	Tilte XIX: Nondiscrimination Against the Handicapped
SRS–IM–77–22	—	Title XIX: SSI Benefit Increases Affecting Medicaid Eligibility

SRS–IM–77–23	—	Institute for Medicaid Management Patient/ Provider Profile Conference Atlanta, June 8–10, 1977
SRS–IM–77–24	—	State Medicaid Management Surveys Information
SRS–IM–77–25	—	Title XIX: SS Act: Physician Certification to Override Maximum Allowable Cost Limits on Prescribed Drugs
SRS–IM–77–26	—	List of Directors of Single State Agencies and Umbrella Agencies, and MAVs (Supersedes SRS–IM–76–55)
SRS–IM–77–27	—	Title XIX SS Act: Pre-publication Draft Guidelines on Payment of Reasonable Charges for Prescribed Drugs (Refer to SRS–AT–75–72)
SRS–IM–77–28	—	Institute for Medicaid Management Conference on Institutional Reimbursement, Milwaukee, Wisconsin, July 19–22, 1977, at Holiday Inn
SRS–IM–77–29	—	IMM 1978 Program and Needs for Repository
SRS–IM–77–31	—	Review of Shows for Treatment: Nine State Survey of EPSDT
SRS–IM–77–32	—	New Technology Available in Screening and Detection of Lead Poisoning, and EPSDT
SRS–IM–77–33	—	Price Information for Drug Products/SSA
SRS–IM–77–34	—	Title XIX, SS Act: Summary of DHEW Regs. on Nondiscrimination on the Basis of Handicaps (Refer to IM–77–21)
SRS–IM–77–35	—	Data on Drug Bioavailability Studies
SRS–IM–77–36	—	Institute for Medicaid Management Conference on Hospital Reimbursement, Milwaukee, Wisconsin, 7/19–21/77 (Refer to IM–77–29)
HCFA–IM–77–17	—	IMM Conference: Independent Professional Review of ICF Services for the Mentally Retarded, Kansas City, Mo., 8/7–8, 1977
HCFA–IM–77–18	—	IMM Meeting on Coordination of Fed State Training Resources, Needs & Activity to Upgrade Staff Capability

HCFA–IM–77–49	—	Title XIX, SSA: Price Monthly Information for Drug Products, Notice of Monthly Distribution of Decile Data. (Refer to SRS–AT–75–72)
HCFA–IM–77–50	—	Transmittal of Additional Information Relating to HCFA–IM–77–43, Concerning National Association of Blue Shield Plans, Medical Necessity Program
HCFA–IM–77–51	—	Title XIX, SSA: State Award of Contracts
HCFA–IM–77–52	—	Conference on Medicaid and the Health Care Provider: Can the Partnership Work More Effectively
HCFA–IM–77–53	—	List of Single State Agency Directors and MAU Directors (Supersedes IM–77–26.)
HCFA–IM–77–54	—	Title XIX, SSA: Limitation on Payment or Reimbursement for Drugs (Refer to SRS–AT–75–72)
HCFA–IM–77–55	—	Title XIX, SSA: Alternative Reimbursement Approaches for Laboratory Services
HCFA–IM–77–56	—	Transmittal of a Guide to Administration, Diagnosis and Treatment-EPSDT
HCFA–IM–77–57	—	Transmittal of EPSDT Training Materials
HCFA–IM–77–58	—	Final Food and Drug Administration Regulations on Hearing Aid Devices
HCFA–IM–77–59	—	Revisions to Medicaid Quality Control System
HCFA–IM–77–60	—	Title XIX, SSA: Alternate Rate-Setting Approaches for HMOs
HCFA–IM–77–61	—	Title XIX, SSA: Limitation on Payment or Reimbursement for Drugs (Refer to SRS–AT–75–72 and HCFA IM–77–54)
HCFA–IM–77–62	—	Proposed State Agency Management Self Appraisal Module (SAMSAM)
HCFA–IM–77–63	—	Training Sessions in the Area of Fraud and Abuse for State Investigators
HCFA–IM–77–64	—	Summary of Meeting Sponsored by the IMM Training Needs Assessment

HCFA–IM–77–65	—	Journal for Medicaid Management
HCFA–IM–77–66	—	Medicare-Medicaid Anti-Fraud and Abuse Amendments to the SSA (P.L. 95–142, Oct. 25, 1977.)
HCFA–IM–77–67	—	Title XIX, SSA: Limitation on Payment or Reimbursement for Drugs (Refer to SRS–AT–75–72)
HCFA–IM–77–68	—	Workshops on MARS/SUR of the MMIS
HCFA–IM–77–69	—	List of Single State Agency Directors and MAU Directors
HCFA–IM–77–70	—	Medicaid Interagency Agreements Workshops
HCFA–IM–77–71	—	Personnel Resources Inventory
HCFA–IM–78–1	—	Amendments to the SSA to Provide Payment for Rural Health Clinic Services (P.L. 95–210, 12–13–77)
HCFA–IM–78–2	—	Medicaid Interagency Agreements Workshops

POLICY INTERPRETATION QUESTIONS

The Policy Interpretation Questions (PIQs) are a series of policy interpretations responded to by the Medicaid Bureau, pertaining to issues which need to be clarified in administering the Medicaid program. A numeric listing of these Policy Interpretation Questions follows:

PIQ–74–23	—	Reasonable Charges
PIQ–74–25	—	Transplant Services (Renal) Title XIX Recipients
PIQ–74–30	—	By Counties to States for Medicaid Programs—Title XIX
PIQ–74–38	—	Cost Differential Between SNFs and ICFs
PIQ–74–40	—	Coordination Between Titles XVIII and XIX
PIQ–74–46	—	Retention and Custodial Requirements for Records
PIQ–74–47	—	Effective Date of Medicaid Entitlement
PIQ–74–59	—	Requirement for Prior Approval of Negotiated Procurements

PIQ–74–64	—	Maintenance of Effort for MR in ICF
PIQ–74–67	—	Waiver of Title XVIII Utilization Review Requirements
PIQ–74–68	—	Exemptions, under section 1902(a)(23) of Medicaid HMO Contracts from the Statewideness and Comparability Provisions of Sections 1902(a)(1) and 1903(a)(10)
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PIQ–75–67	—	Standards and Principles of Cost Reimbursement
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PIQ–75–119	—	Charging a Recipient for Reserving Beds When State Will Not Pay
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PIQ–75–121	—	System of Disbursement of Monies
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PIQ–76–24 — State Title XIX Cutback Legislation Affecting Reimbursement and Possible Questions of Compliance

PIQ–76–27 — Differential in Personal Needs for Categorically Needy and Medically Needy

PIQ–76–32 — FFP Available for Chiropractic Services Under Medicare

PIQ–76–33 — Medicaid Need for IPR When Patient Level of Care Changes

PIQ–76–34 — Confidentiality to be Upheld by Obtaining Consent for Release of Information Required by Medicaid

PIQ–76–36 — Eligibility for Retroactive Coverage

PIQ–76–43 — Long-Term Care Survey and Certification Expenditure Reimbursement

PIQ–76–45 — Consolidation of Single State Agency and Medical Assistance Unit

PIQ–76–51 — Definition of SNF Care: Needed on Daily or Inpatient Basis

PIQ–76–52 — SNF Certification & FFP Require Reimbursement of Medical Director

PIQ–76–60 — Deficiencies Terminate FFP for Nursing Homes

PIQ–76–63 — MR/IPR Records Must be Retained for Three Years

PIQ–76–66 — Economic Index Limitation on Prevailing Charges Applicable to Dentists

PIQ–76–75 — Implementation of ICF Certification Standards in Old-Age Homes

PIQ–76–77 — Additional Medicaid Coverage Three section 1902(f)

PIQ–76–80 — Hospital Reimbursement Rates Decided by State Rate Review Board

PIQ–76–85 — Comprehensive Dental Services Required for ICF/MR

PIQ–76–86 — Supplement D of Handbook of Medical Assistance Obsolete Except D–5840

PIQ–76–88 — Determination of Medicaid Eligibility as Categorically or Medically Needy

PIQ–76–90	—	Medicaid Coverage of "Reasonable Classifications" (Optional Supplementary Payment Recipients)
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PIQ–76–102	—	Title XIX Medical Ineligible Title XX Funds as Social Services
PIQ–76–107	—	Purchase of Services Occurs When Payment Made to Private Provider
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PIQ–76–114	—	Computation of Expenditures for In and Out-Patient Facilities
PIQ–76–115	—	FFP for Title XIX Services to Child Care Institutions
PIQ–76–116	—	Utilization Review Committee Physicians Not Liable
PIQ–76–117	—	State Agency Responsible for Placement of SNF Patients
PIQ–76–119	—	Availability of 100% FFP for Survey of SNFs and ICFs.
PIQ–76–121	—	Licensure Necessary for Reimbursement of Medicaid Practitioners
PIQ–76–127	—	FFP for Reserved Beds in ICF–MR Facilities
PIQ–76–128	—	Determination of Eligibility as Categorically or Medically Needy
PIQ–76–131	—	Termination of Medicaid Eligibility for Failure to Cooperate Re: Insurance
PIQ–76–132	—	Costs of Inspection of SNF: Met Equally by Titles XVIII & XIX for 100% FFP
PIQ–76–136	—	Health Insurance and Fiscal Agent Contracts —FFP Rates
PIQ–76–137	—	Disabled Ineligible SSI Because SGA Ineligible Title XIX
PIQ–76–139	—	Performance of Utilization Review by Medical Director of SNF

PIQ–76–140 — Regional Commissioner Reviews Estimated Expenditures Expected to Exceed $100,000, Not Contract

PIQ–76–144 — State Imposition of Dual Certification of SNFs & ICFs as Requirement

PIQ–76–145 — Available V.A. SNF Care Should be Used by Veterans as is Third Party Resource

PIQ–76–149 — Retroactive Increase of Reimbursement Rate for ICF/MR Prohibited

PIQ–76–150 — Contracts Shoud be Extended or Renewed When Open Bidding Not in Public Interest

PIQ–76–151 — State May Deny Payment to Hospital if Stay Unnecessary Per UR Committee

PIQ–76–154 — Responsibilities of MR Team Physician to Patient and Facility Records

PIQ–76–155 — Medicaid Cannot Use Same Guidelines as Medicare in Determining Need for Skilled Care

PIQ–76–163 — Inspection Survey and Certification Long-Term Care Facilities

PIQ–76–167 — Condition of Provider Participation and Agreement

PIQ–76–169 — Inpatient Psychiatric Hospital Admission Reviews for Individuals Under 21

PIQ–76–175 — Recording Expenditures for Purchase of Service Contractors

PIQ–76–179 — Plan Amendment Implementing Payments

PIQ–76–184 — Treatment of Third Party Resources as it Relates to Interim Payment Rates for Inpatient Hospital Services

PIQ–76–188 — Reserved Bed Policy in LTC Facilities and Placement of MR Patients in General ICFs

PIQ–76–189 — Clarification of FFP as it Relates to Family Planning Expenditures Under Titles XIX and XX

PIQ–76–194 — Payment to Public Health (PHS) Grant Support Centers for Services to Medicaid Eligibles

PIQ–76–197	—	Coverage in Noncertified Long-Term Care Facilities
PIQ–76–199	—	Services to Individuals Living in Hospitals, Nursing Homes or Intermediate Care Facilities
PIQ–77–2	—	Clarification of Title
PIQ–77–4	—	Public Services of State's Share
PIQ–77–5	—	Confidentiality of Medicaid Fraud and Abuse Information
PIQ–77–6	—	Procedures Regarding Timely and Adequate Notice

Program Instructions*

The Program Instructions (PIs) were policy issue papers issued by the former Social and Rehabilitation Service to its various components. The numeric listing of PIs which follows refers only to those issued by the Medical Assistance Administration, SRS, which was transferred to the Health Care Financing Administration by the Secretary of HEW's Reorganization Order of March 8, 1977.

MSA–PI–73–2	—	EPSDT Information Via Mass Media
MSA–PI–74–11	—	Child Abuse
MSA–PI–75–4	—	ICF for the Mentally Retarded: Inappropriate Placement
MSA–PI–75–8	—	ICF and SNF Survey and Certification Reports
MSA–PI–75–13	—	Providers' Claim—Certification as to Validity of Claim

* The Program Instructions series and the Program Regulation Guides are no longer published.

Program Regulation Guides*

The Program Regulation Guides (PRGs) were interpretations of program regulations issued by the former Social and Rehabilitation Service and were sent to all components of the agency. The numeric listing that follows refers to only those PRGs which were issued by the Medical Assistance Administration, SRS, that was transferred to the Health Care Financing Administration by the Secretary of HEW's reorganization order of March 8, 1977.

MSA–PRG–1	—	Issuance of New MA Manual Transmits a Part of the New MSA Manual
MSA–PRG–5	—	Fair Hearings
MSA–PRG–6	—	Licensure of NH Administrators—Qualities of Suitability
MSA–PRG–7	—	Roles of a State Medical Care Advisory Committee
MSA–PRG–12	—	Prior Authorization
MSA–PRG–14	—	Common Provider Audit Program—Inpatient Hospital Services
MSA–PRG–15	—	Standards for Qualified Personnel Who Perform Surveys of SNHs
MCA–PRG–17	—	Transportation for Recipients of Med. Assis.
MSA–PRG–17a	—	Transportation for Recipients of Med. Assis.
MSA–PRG–18	—	Free Choice of Providers
MSA–PRG–18a	—	Free Choice of Providers; Renumbering of Basic Regulation for Transportation of Recipients of Medical Assistance
MSA–PRG–20	—	Services and Payment in MAPs—Assistance to Aged Individuals in Institutions for Mental Diseases
MSA–PRG–21	—	Services and Payment in MAPs
MSA–PRG–23	—	Provider Fraud
MSA–PRG–24	—	EPSDT
MSA–PRG–25	—	Medical Review in SNH and Mental Hospitals
MSA–PRG–26	—	State Organization—MAU

* The Program Instructions series or the Program Regulation Guides are no longer published.

MSA–PRG–27	—	EPSDT
MSA–PRG–29	—	Reasonable Charges Amendment: Inpatient Hospital Services
MSA–PRG–30	—	Interrelation with State Health & VR Agencies and with Title V Grantees
MSA–PRG–30a	—	Interrelations with State Health & State VR Agencies and with Title V Grantees (MSA–PRG–30, May 13, 1974)
MSA–PRG–31	—	FFP for Mechanized Claims Processing and Information Retrieval Systems
MSA–PRG–32	—	Penalty for Failure to Provide Child Health Screening Services Under Medicaid
MSA–PRG–34	—	Questions & Answers on Facilities Serving the Mentally Retarded
MSA–PRG–35	—	EPSDT for Eligible Individuals Under 21

HEALTH STANDARDS AND QUALITY BUREAU

STATE OPERATIONS MANUAL AND HEALTH STANDARDS AND QUALITY BUREAU—STANDARDS AND CERTIFICATION STATE LETTER (STATE AGENCY LETTERS)

The State Operations Manual and State Agency Letters are instructional materials issued by the Administration governing State Agency responsibilities for making initial and subsequent determinations as to the compliance of providers of services; i.e., hospitals, skilled nursing facilities and home health agences and, for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency or public health agency, with the conditions of participation for such facilities under the Medicare program. Copies are available for inspection and copying at all Health Care Financing Administration Regional Offices.

Part One—Contains a general description of Federal-State operating relationships in carrying out the objectives of the title XVIII section 1864 certification program, including the interrelationships with other programs such as State Welfare, comprehensive health planning, licensure, etc.

Part Two—Provides the basic procedural instructions for conducting surveys and related State agency operations with providers of services and for submitting certifications to the Health Standards and Quality Bureau. It includes interpretive statements to show how individual conditions of participation may be applied in certain situations to achieve national uniformity in applying the criteria used by the States in recommendations of certification. It also contains the Life Safety Code.

Part Three—Consists of instructions and aids for State agency administration and for financial management. This section is of interest primarily to State Agency administrators and fiscal officers.

PROVIDER CERTIFICATION MEMORANDA TO REGIONAL OFFICES, HSQ

A series of numbered issuances intended expressly for administrative communications to Regional Offices. PCMs may occasionally include temporary instructions issued to HSQ ROs which are either to become obsolete or reissued as manual instructions within a short period of time. PCMs inform their audience of, for example, studies, meetings, training sessions, reporting requirements, projections and other program matters. Copies may be requested in any Health Care Financing Administration Regional Office.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TRANSMITTALS*

The Professional Standards Review Organizations (PSRO) transmittals contain administrative, procedural, and policy instructions for use in administering the PSRO program. A numeric listing of these PSRO transmittals follows:

PSRO Transmittal No. 1 & 2	—	Introduction of BQA–PSRO Transmittal Memorandum (8/2/74)
PSRO Transmittal No. 3	—	Roles and Responsibilities (8/8/74)
PSRO Transmittal No. 4	—	Monthly Reporting From Statewide PSRO Support Centers (8/8/74)
PSRO Transmittal No. 5	—	PSRO Travel Requests (8/21/74)
PSRO Transmittal No. 6	—	Tax Exemption for PSROs (9/3/74)
PSRO Transmittal No. 7	—	The Role of Continuing Education in PSROs (10/1/74)
PSRO Transmittal No. 8	—	Subcontracting—Allowable Activities (9/30/74)
PSRO Transmittal No. 9	—	Baseline Data (10/18/74)
PSRO Transmittal No. 10	—	Planning PSRO Transition to Conditional PSRO Status (11/5/74)

* The PSRO Transmittals Nos. 1—46 were issued by the Bureau of Quality Assurance (BQA) prior to the reorganization order of the Secretary, HEW, when BQA was a part of the Health Services Administration. The responsibilities for the PSRO program were transferred to the new Health Care Financing Administration created by the HEW reorganization of 3/8/77.

PSRO Transmittal No. 11 — The PSRO-Short Stay Hospital Relationship and Delegation of Review Functions (11/26/74)

PSRO Transmittal No. 12 — Full-Time PSRO Executive Director (12/5/74)

PSRO Transmittal No. 13 — Accordance by Present Conditional PSROs and PSRO Program Policy (1/30/75)

PSRO Transmittal No. 14 — PSRO Planning Projects Coordination with Medicaid and Maternal and Child Health and Crippled Children's Programs State Agencies (1/31/75)

PSRO Transmittal No. 15 — Reconsideration of Negative Findings by a PSRO on the Capability of a Hospital to Perform Effective Review (2/12/75)

PSRO Transmittal No. 16 — Specifications for Confidentiality Policy on PSRO Data and Information (2/14/75)

PSRO Transmittal No. 17 — BQA Contract with AMA for Development of Model Criteria Sets (2/18/75)

PSRO Transmittal No. 18 — PSRO Support Center Policy (4/23/75)

PSRO Transmittal No. 19 — Proposed Regulations for the Membership, Organization and Functions of Advisory Groups to Professional Standards Review Organizations (5/13/75)

PSRO Transmittal No. 20 — PSRO Data Routing and Processing Policies and the Federal Reports Manual of the PSRO Management Information System (PMIS) (5/30/75)

PSRO Transmittal No. 21 — Relationship of PSRO Review Responsibilities to the Medicare and Medicaid Programs — Secretarial Decision of February 24, 1975 (6/20/75)

PSRO Transmittal No. 22	—	Clarification of Relationship of Utilization Regulations to the PSRO Program (6/20/75)
PSRO Transmittal No. 23	—	Addendum to Transmittal No. 22 (7/2/75)
PSRO Transmittal No. 24	—	Addendum to Transmittal No. 14 —Update of Listing of Medicaid State Agency Units (8/11/75)
PSRO Transmittal No. 25	—	Guidelines for Complying with BQA Requirements for Data Deliverable Under Both the Conditional Contract and the Provisional Data Routing and Processing Policy (8/26/75)
PSRO Transmittal No. 26	—	Revisions to Transmittal 20: Changes to Provisional Policies for PSRO Data Routing and Processing and Federal Reports Manual of PSRO Management Information System (PMIS) (9/12/75)
PSRO Transmittal No. 27	—	Instructions to PSROs Regarding Financing of PSRO Delegated Hospital Review (12/18/75)
PSRO Transmittal No. 28	—	Preparation and Submission of Reports Required by BQA (1/9/76)
PSRO Transmittal No. 29	—	Hearings and Appeals in the PSRO Program (2/21/76)
PSRO Transmittal No. 30	—	Relationship of Physician Certification Requirements Under PSRO to the Medicare and Medicaid Programs — Secretarial Decision of June 16, 1975 (2/27/76)
PSRO Transmittal No. 31	—	Contract Management Manual (3/2/76)
PSRO Transmittal No. 32	—	Notification to Patients Regarding Data Collection and Confidentiality Policies (3/2/76)
PSRO Transmittal No. 33	—	Health Systems Agencies (HSAs) and Proposed Revision of Chapter II of the PSRO Program Manual on PSRO Area Designation (4/5/76)

PSRO Transmittal No. 34 — Reimbursement to Delegated Hospitals Under Section 112, Public Law 94–182 (4/9/76)

PSRO Transmittal No. 35 — Changes in Reimbursement Policies for Selected Contract Expenditures (undated)

PSRO Transmittal No. 37 — Professional Standards Review Organization (PSRO) Review of Non-Federally Reimbursed Patient Care (6/28/76)

PSRO Transmittal No. 38 — PSRO–Title V Relationships (7/2/76)

PSRO Transmittal No. 39 — Clarification of PSRO Data Routing and Processing Policies and Bureau Plans for the Evaluation of Those Policies (8/11/76)

PSRO Transmittal No. 40 — Decentralization of PSRO Program Operations (10/6/76)

PSRO Transmittal No. 41 — Revisions and Addendums to Transmittal No. 16—Effective Upon Issuance (10/6/76)

PSRO Transmittal No. 42 — Revisions to Reporting Requirements as Issued in Transmittal 21 (10/6/76)

PSRO Transmittal No. 43 — Bureau of Quality Assurance (BQA) Policy on Medical Care Evaluation (MCE) Studies (1/25/77)

PSRO Transmittal No. 44 — Policies Applicable to PSROs Involving Health Care Practitioners Other Than Physicians in Peer Review in Short-Stay Hospitals (1/25/77)

PSRO Transmittal No. 45 — Clarification of Provisional Policies for PSRO Data Routing and Processing with Regard to Integration with Existing Systems (2/1/77)

PSRO Transmittal No. 46 — Reimbursement to Delegated Hospitals and PSROs under Section 112, P.L. 94–182 (3/11/77)

PSRO Transmittal No. 47	—	Review and Approval Process for PSRO Requests for Proposals for a Data Processor and Data Subcontracts (5/13/77)
PSRO Transmittal No. 48	—	PSRO Determinations of Medical Necessity and Appropriateness of Level of Care-Relationship to Medicare Reimbursement (6/3/77)
PSRO Transmittal No. 49	—	PSRO Review in Indian Health Service (IHS) Institutions (6/3/77)
PSRO Transmittal No. 50	—	Additions, Clarifications and Modifications to Instructions for Preparation and Submission of PHDDS Tapes (Supplement to PSRO Transmittal No. 28) (8/24/77)
PSRO Transmittal No. 51	—	Revised Professional Standards Review Organization Management Information System (PMIS) Federal Reports. Manual Cost Reporting Instructions (8/30/77)
PSRO Transmittal No. 52	—	Physician Reimbursement Rate (9/2/77)
PSRO Transmittal No. 53	—	PSRO Review of Medicaid and Medicare "Pending Eligibles" (11/21/77)
PSRO Transmittal No. 54	—	Ancilliary Services Review (11/3/77)
PSRO Transmittal No. 55	—	Executive and Medical Director Salary Levels (11/14/77)
PSRO Transmittal No. 56	—	PSRO Support Center Policy (11/14/77)
PSRO Transmittal No. 57	—	Reimbursement to Hospitals Delegated *Only* the Performance of Medical Care Evaluation Studies (MCEs) (7/15/77)
PSRO Transmittal No. 58	—	Civil Rights Responsibilities of PSROs (11/15/77)

PSRO Transmittal No. 59 — The Relationship of Health Systems Agencies and Professional Standards Review Organizations—Department of Health, Education, and Welfare Policy Statement on HSA/PSRO Relationships (11/29/77)

LEGISLATIVE HISTORY OF PSRO PROVISIONS OF SSA AMENDMENTS

This publication contains reprints of reports and Congressional actions regarding the PSRO program.

PSRO FACT BOOK

PSRO PROJECT OFFICER MANUAL

The PSRO Project Officer's Manual is a guide used by HEW Regional Project Officers in their operating responsibilities toward PSROs.

ANNUAL REPORT OF THE NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

This is an annual report of the Council to the Secretary of HEW.

OFFICE OF PROGRAM INTEGRITY

PROGRAM INTEGRITY MEMORANDA

Program Integrity Memoranda are temporary instructions issued to the Office of Program Integrity regional offices. This information is designed for use by Acting Program Integrity Directors and other interested parties. These instructions are generally later reissued as manual instructions. Copies of the instructions are available for inspection and copying in all Health Care Financing Administration Regional Offices.

OTHER PROGRAM INTEGRITY INSTRUCTIONS

Other Program Integrity instructions are contained in the following HCFA program manuals and guides:

A. Medicare Part A Intermediary Manual and Letters
B. Medicare Carriers Manual and Letters
C. Health Insurance Regional Office Manual
D. Medicare Bureau Identical Memoranda
E. Medicare Bureau Program Circulars
F. Medicare Bureau Annual Contractor Evaluations Reports
G. Medicaid Claims Validation Guides
H. Medicaid Field Staff Instruction and Information Series
I. Medicaid Action Transmittals
J. Medicaid Program Regulation Guide

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medicaid
Information Memorandum

Department of Health and Human Services

Health Care Financing Administration

No. 81-11

Date July 1981

FBL-1

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAM

SUBJECT: Current Status of Action Transmittals and Information Memorandums

INFORMATION: The following is a listing of Action Transmittals (ATs) and Information Memorandums (IMs) currently in effect. All others may be discarded.

AT	AT	AT	IM
79-60	80-1	80-55	79-29
79-61	80-3	80-56	79-33

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79-63	80-4	80-59	79-34
79-64	80-8	80-60	79-38
79-67	80-9	80-61	79-40
79-68	80-11	80-62	79-41
79-69	80-13	80-64	80-6
79-70	80-15	80-65	80-9
79-71	80-16	80-68	80-11
79-72	80-17	80-70	80-13
79-73	80-18	80-71	80-19
79-74	80-19	80-73	80-22
79-76	80-20	80-74	80-23
79-77	80-21	80-75	80-25
79-78	80-22	80-76	80-26
79-79	80-23	80-78	80-27
79-80	80-24	80-80	80-28
79-83	80-25	80-81	80-29
79-86	80-27	80-82	80-31
79-87	80-28	80-83	80-32
79-88	80-29	80-84	80-33
79-89	80-32	80-85	80-34
79-90	80-35	80-87	80-35
79-91	80-38	80-88	80-37
79-98	80-39	80-89	
79-101	80-42	80-90	
79-102	80-43	80-91	
79-103	80-46	80-92	
79-104	80-48	80-93	
79-107	80-49	80-94	
79-108	80-50		
	80-52		

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